NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Strategy Task Force
In-Person Meeting #1

National Quality Forum Conference Center
1030 15th Street NW, 9th Floor, Washington, DC 20005

PUBLIC DIAL-IN: 877-718-5092
PASSCODE: 7969424

WEB ACCESS: HTTP://WWW.MYEVENTPARTNER.COM/NQFORUM118

AGENDA: APRIL 12, 2012

Meeting Objectives:
- *Set MAP 3-year strategic goals for performance measurement to enable improvement, transparency, and value*
- *Review ongoing measure evaluation efforts and discuss MAP evaluation strategy*
- *Discuss proposed MAP 2012-2013 scope of work*
- *Define enhancements to the MAP Measure Selection Criteria*
- *Determine how to strengthen MAP-NPP alignment*
- *Finalize approach for the strategic plan outline due to HHS June 1*

11:00 am   **Welcome and Review of Meeting Objectives**
Chip Kahn and Gerry Shea, Strategy Task Force Co-Chairs

11:05 am   **Performance Measurement for Improvement, Transparency, and Value and MAP 3-Year Strategic Goals**
Chip Kahn

12:40 pm   **Opportunity for Public Comment**

12:45 pm   **Lunch**

1:00 pm   **Measure Evaluation Efforts and MAP Evaluation Strategy**
Chip Kahn
TBD- Mark McClellan and Patrick Conway

2:15 pm   **Proposed MAP 2012-2013 Scope of Work**

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Gerry Shea
Tom Valuck, Senior Vice President, Strategic Partnerships, NQF

2:45 pm   **Enhancing MAP's Measure Selection Criteria**
Chip Kahn
Connie Hwang, Vice President, Measure Applications Partnership, NQF

3:30 pm   **MAP-NPP Relationship**
Gerry Shea
Bernie Rosof, National Priorities Partnership Co-Chair

4:10 pm   **Opportunity for Public Comment**

4:15 pm   **Summary and Next Steps**
Chip Kahn and Gerry Shea
- Finalize approach for June 1 deliverable to HHS
- Coordinating Committee engagement
- Action plan development

4:30 pm   **Adjourn**

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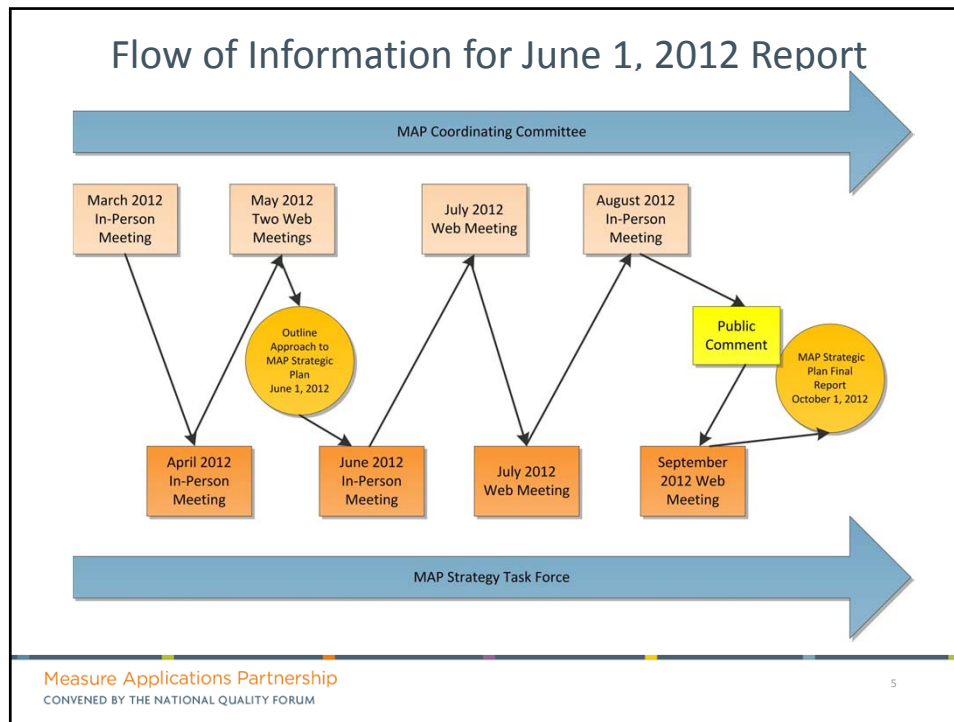
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April 12, 2012

Welcome and Review of Meeting Objectives

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Meeting Objectives

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MAP Strategy Taskforce Membership

- **Chip Kahn, Member of MAP Coordinating Committee (co-chair)**
- **Gerry Shea, Member of MAP Coordinating Committee (co-chair)**
- George Isham, MAP Coordinating Committee co-chair
- Beth McGlynn, MAP Coordinating Committee co-chair
- Helen Darling, National Priorities Partnership co-chair
- Bernie Rosof, National Priorities Partnership co-chair
- Alice Lind, MAP Dual Eligible Beneficiaries Workgroup chair
- Mark McClellan, MAP Clinician Workgroup chair
- Frank Opelka, MAP Hospital Workgroup chair
- Carol Raphael, MAP PAC/LTC Workgroup chair
- Christine Bechtel, MAP Coordinating Committee member
- Nancy Wilson, MAP Coordinating Committee member (federal agency liaison)
- Patrick Conway, MAP Coordinating Committee member (federal agency liaison)

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Flow of Information for June 1, 2012 Report

Agenda

- Welcome and Review of Meeting Objectives

- Performance Measurement for Improvement, Transparency, and Value and MAP 3-Year Strategic Goals

- Measure Evaluation Efforts and MAP Evaluation Strategy

- Proposed MAP 2012-2013 Scope of Work

- Enhancing MAP's Measure Selection Criteria

- MAP-NPP Relationship

- Summary and Next Steps

Performance Measurement for Improvement, Transparency, and Value and MAP 3-Year Strategic Goals

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Goal Setting

Performance Measurement

- How do we achieve performance measurement that enables improvement, transparency, and value?

MAP

- How do we ensure MAPs decisions advance the aims, priorities, and goals of the National Quality Strategy?

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Opportunity for Public Comment

*Measure Evaluation Efforts and
MAP Evaluation Strategy*

Assessment of CMS Quality Measures

Patrick Conway, MD
Chief Medical Officer
Centers for Medicare and Medicaid Services

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Information for Health Care Improvement

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CMS Goal for Impact Assessment

To assess the impact of CMS measures and measurement programs on better quality of care, better health, and lower costs in order to inform measure selection and implementation policies

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Affordable Care Act (ACA) Requirements

Sec. 3014 of the Affordable Care Act establishes a new federal "pre-rulemaking process" for the adoption of quality measures that includes
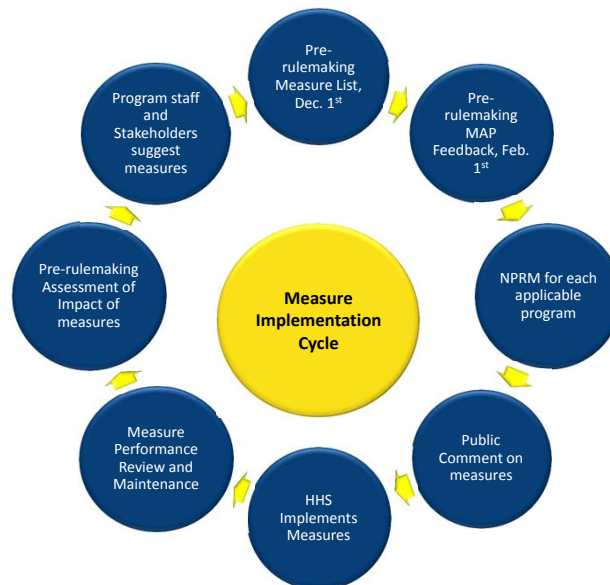
- **Making publicly available by December 1st annually a list of measures currently under consideration by HHS for qualifying programs;**

- **Providing the opportunity for multi-stakeholder groups to review and provide input by February 1st annually to HHS on the measures under consideration, and for HHS to consider this input;**

- **Publishing the rationale for the selection of any quality and efficiency measures that are not endorsed by the National Quality Forum (NQF); and**

- **Assessing the impact of endorsed quality and efficiency measures at least every three years (the first report due to the public in March 2012).**

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Measure Selection Process

Pre-rulemaking Measure List, Dec. 1st

Program staff and Stakeholders suggest measures

Pre-rulemaking MAP Feedback, Feb. 1st

Pre-rulemaking Assessment of Impact of measures

Measure Implementation Cycle

NPRM for each applicable program

Measure Performance Review and Maintenance

Public Comment on measures

HHS Implements Measures

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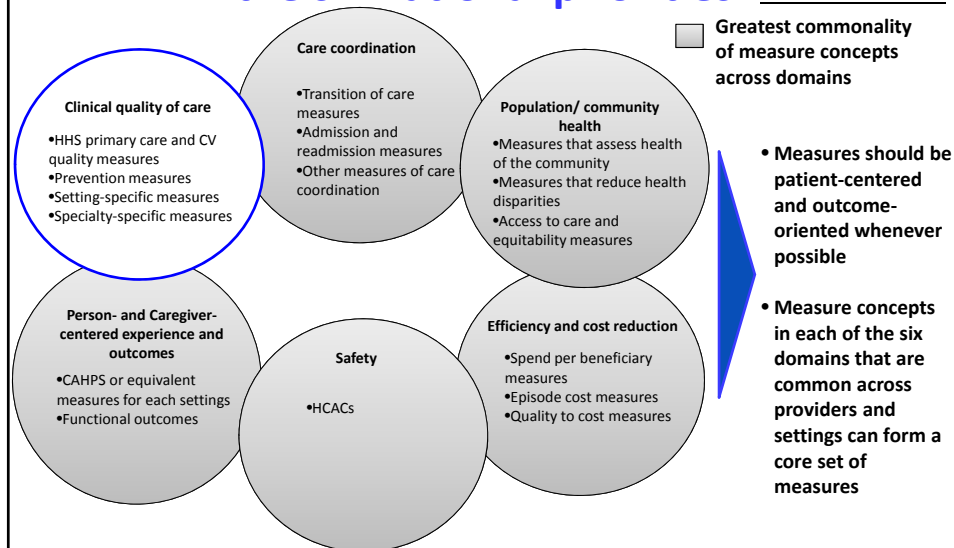
High Level Objectives for Measure Selection

- Align measures with the National Quality Strategy
- Align measures across programs
- Focus on patient centered measures
- Parsimonious sets of measures when possible; core sets of measures and measure concepts
- Removal measures no longer appropriate
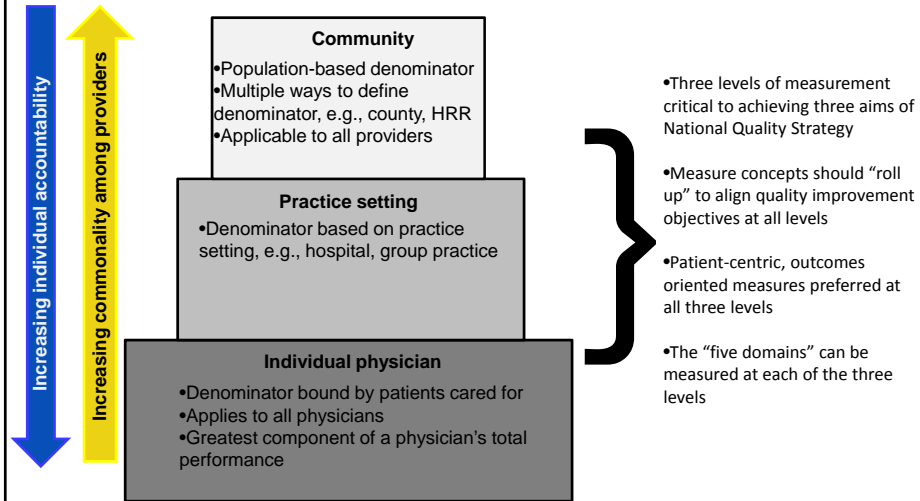
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CMS framework for measurement maps to the six national priorities PRELIMINARY

☐ Greatest commonality of measure concepts across domains

Care coordination
- Transition of care measures
- Admission and readmission measures
- Other measures of care coordination

Clinical quality of care
- HHS primary care and CV quality measures
- Prevention measures
- Setting-specific measures
- Specialty-specific measures

Population/ community health
- Measures that assess health of the community
- Measures that reduce health disparities
- Access to care and equitability measures

Person- and Caregiver-centered experience and outcomes
- CAHPS or equivalent measures for each settings
- Functional outcomes

Safety
- HCACs

Efficiency and cost reduction
- Spend per beneficiary measures
- Episode cost measures
- Quality to cost measures

- **Measures should be patient-centered and outcome-oriented whenever possible**

- **Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures**

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Quality can be measured and improved at multiple levels

Increasing individual accountability

Increasing commonality among providers

Community
- Population-based denominator
- Multiple ways to define denominator, e.g., county, HRR
- Applicable to all providers

Practice setting
- Denominator based on practice setting, e.g., hospital, group practice

Individual physician
- Denominator bound by patients cared for
- Applies to all physicians
- Greatest component of a physician's total performance

- Three levels of measurement critical to achieving three aims of National Quality Strategy
- Measure concepts should "roll up" to align quality improvement objectives at all levels
- Patient-centric, outcomes oriented measures preferred at all three levels
- The "five domains" can be measured at each of the three levels

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CMS quality reporting and performance programs

PRELIMINARY

Hospital Quality	Physician Quality Reporting	PAC and Other Setting Quality Reporting	Payment Model Reporting	"Population" Quality Reporting
• Medicare and Medicaid EHR Incentive Program	• Medicare and Medicaid EHR Incentive Program	• Inpatient Rehabilitation Facility	• Medicare Shared Savings Program	• Medicaid Adult Quality Reporting*
• PPS-Exempt Cancer Hospitals	• PQRS	• Nursing Home Compare Measures	• Hospital Value-based Purchasing	• CHIPRA Quality Reporting*
• Inpatient Psychiatric Facilities	• eRx quality reporting	• LTCH Quality Reporting	• ESRD QIP	• Health Insurance Exchange Quality Reporting*
• Inpatient Quality Reporting		• Hospice Quality Reporting	• Physician Feedback/Value-based Modifier*	• Medicare Part C*
• HAC payment reduction program		• Home Health Quality Reporting		• Medicare Part D*
• Readmission reduction program				
• Outpatient Quality Reporting				
• Ambulatory Surgical Centers				

* Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.

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National Impact Assessment
of
Medicare Quality Measures
March 2012 **Report**

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Inclusion Criteria for Implemented Measures

- Two years of national data are readily available (2006–2010)
- Publicly reported
- NQF-endorsed or were previously NQF-endorsed

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Eight Medicare Programs

- Hospital Inpatient Quality Reporting System (Hospital IQR)
- Hospital Outpatient Quality Reporting (Hospital OQR)
- Physician Quality Reporting System (PQRS)
- Nursing Home (NH)
- Home Health (HH)
- End-Stage Renal Disease (ESRD)
- Medicare Part C (Part C)
- Medicare Part D (Part D)

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Methods

- A variety of data sources:
  - ✓ CMS measure contractors
  - ✓ CMS Web sites that report on Medicare quality measures
- Measures for each of the 8 programs:
  - ✓ organized conceptually by measure type or by service type
  - ✓ results are plotted on trend charts to highlight performance over time
  - ✓ measures were assessed against the NQS priority domains

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Report Limitations

- Descriptive results
- The rates reported represent un-weighted results or simple averages across facilities
- The results are unable to highlight disparities among key subgroups
- Subset of measures

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Summary

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

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Measures Included

- 27 process and outcome measures for acute myocardial infarction, heart failure, and pneumonia

- 8 Surgical Care and Improvement Project (SCIP)

- 10 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

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Hospital IQR Measures

- 5 NQS priorities addressed

- Data are from 2006-2010

- Number of All Reporting Hospitals for Hospital Compare: 4,566 (2006) to 4,528 (2010)

- During the 5-year period, participation by more than 99% of IPPS eligible hospitals

- HCAHPS Reporting Hospitals: 2,595 (2007) to 3,827 (2010)

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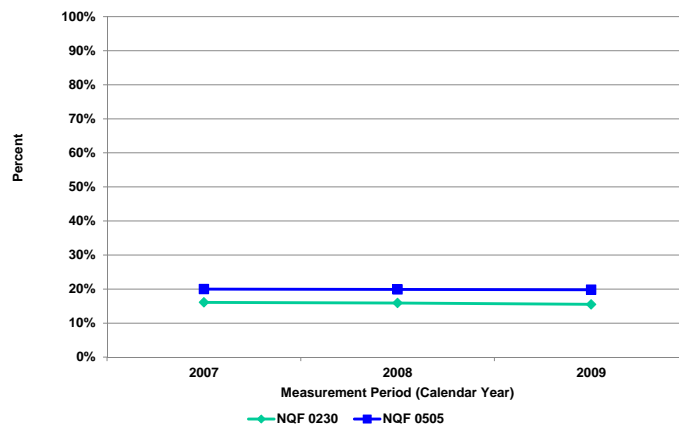*Information for Health Care Improvement*

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AMI at Arrival Measures
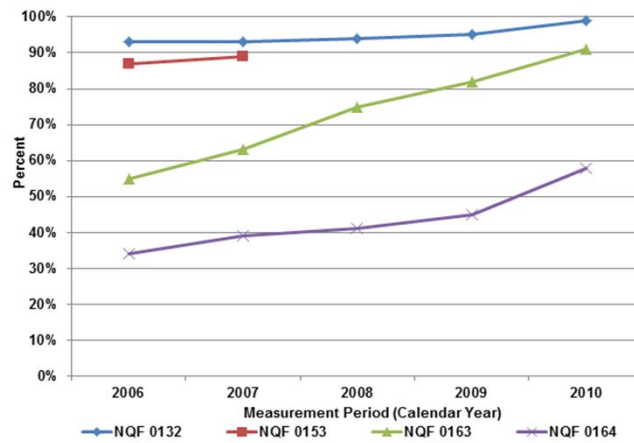
Measure	2006	2007	2008	2009	2010
NQF 0132 – Aspirin at Arrival	93%	93%	94%	95%	99%
NQF 0153 – Beta Blocker at Arrival (retired Q1 2009)	87%	89%	N/A	N/A	N/A
NQF 0163 – PCI Within 90 Minutes	55%	63%	75%	82%	91%
NQF 0164 – Fibrinolytic Medication Within 30 Minutes	34%	39%	41%	45%	58%

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AMI Readmission and Mortality

Measure	2007	2008	2009
NQF 0230 – Mortality	16.1%	15.9%	15.5%
NQF 0505 – Readmission	20.0%	19.9%	19.8%

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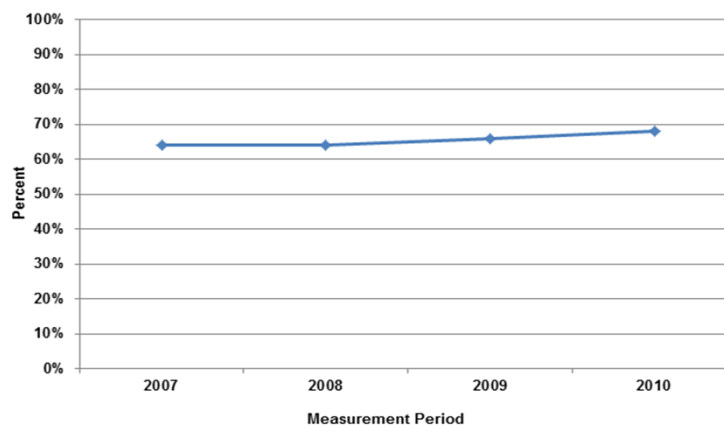## Surgical Care Improvement Project (SCIP)
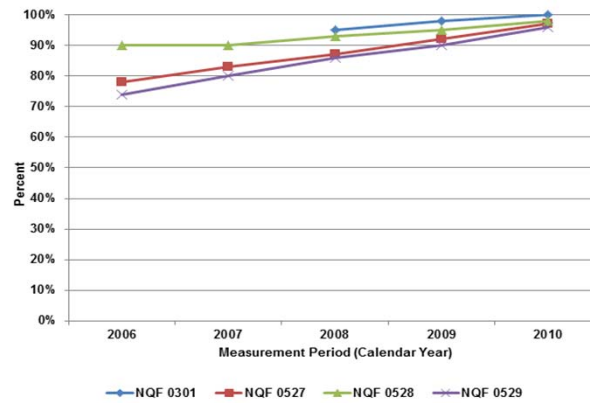
Measure	2006	2007	2008	2009	2010
NQF 0301 – Appropriate hair removal	N/A	N/A	95%	98%	100%
NQF 0527 – Timely receipt of antibiotic	78%	83%	87%	92%	97%
NQF 0528 – Appropriate antibiotic	90%	90%	93%	95%	98%
NQF 0529 – Antibiotics discontinued at right time	74%	80%	86%	90%	96%

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HCAHPS-Overall Hospital Rating

NQF 0166	2007	2008	2009	2010
Overall Hospital Rating	64%	64%	66%	68%

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Hospital IQR Result Highlights

- Consistent increases for nearly all measures
- 7 process measures ↑ of more than 20 percentage points
- In 2010, rates ↑ 90% for the HF & PN measures & all but 1 AMI measure
- SCIP measures showed favorable trends
- Outcome measures exhibited little change
- HCAHPS ↑ in all but one measure, 2007-2010

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Summary

NURSING HOME

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Measures Included

- Process and outcome measures
- 14 chronic or long-stay measures
- 5 post-acute or short-stay measures
- 1 nurse staffing measure with four components
- 5 risk adjusted measures(mobility, catheter, long-stay pain, delirium, and post-acute pressure ulcer)

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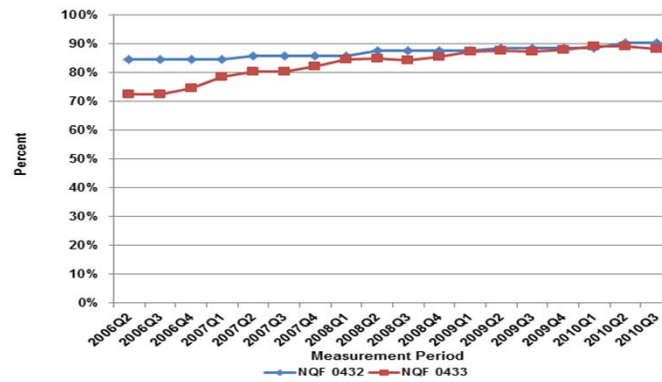*Information for Health Care Improvement*   **HSAG**

Nursing Home Measures

- 3 NQS priorities addressed
- Data are from 2006-2010
- Number of reporting facilities: 15,938 (2006 to 15,697 (2010), a decrease of 241 facilities

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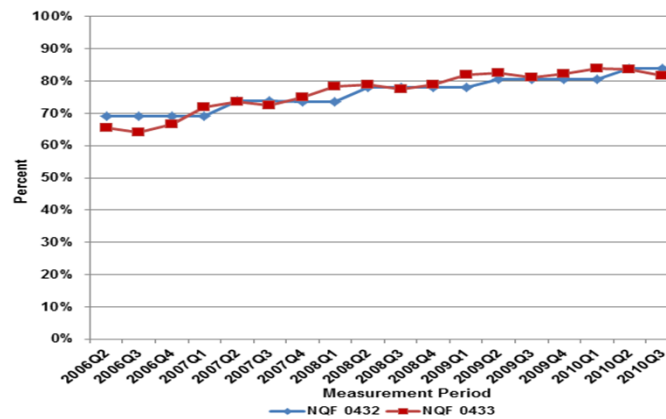
Vaccinations for Chronic Care Residents

Measure	2006 Q4	2007 Q4	2008 Q4	2009 Q4	2010 Q3
NQF 0432-Influenza	84.5	85.9%	87.6%	88.7%	90.4%
NQF 0433-Pneumococcal	74.6	82.3%	85.5%	88.1%	88.2%

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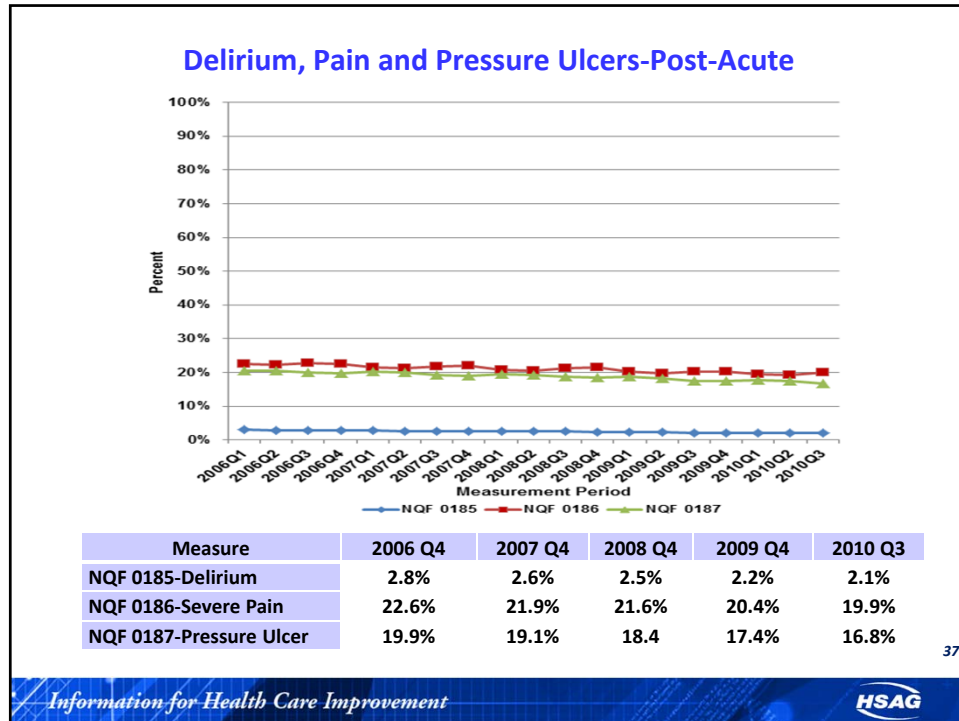
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Vaccination Rates for Post-Acute Residents

Measure	2006 Q4	2007 Q4	2008 Q4	2009 Q4	2010 Q3
NQF 0432-Influenza	69.2%	73.7%	78.0%	80.5%	84.0%
NQF 0433-Pneumococcal	66.7%	74.9%	78.9%	82.3%	81.7%

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Delirium, Pain and Pressure Ulcers-Post-Acute

Measure	2006 Q4	2007 Q4	2008 Q4	2009 Q4	2010 Q3
NQF 0185-Delirium	2.8%	2.6%	2.5%	2.2%	2.1%
NQF 0186-Severe Pain	22.6%	21.9%	21.6%	20.4%	19.9%
NQF 0187-Pressure Ulcer	19.9%	19.1%	18.4	17.4%	16.8%

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Nursing Home Result Highlights

- Of the 14 chronic care measures, 12 showed positive trends
- The 2 immunization measures for chronic care increased by more than 10 percentage points
- All 5 post-acute care measures showed favorable trends
- Specifically, the percentage of post-acute residents with pressure ulcers decreased: 17.9 to 11.6 percent
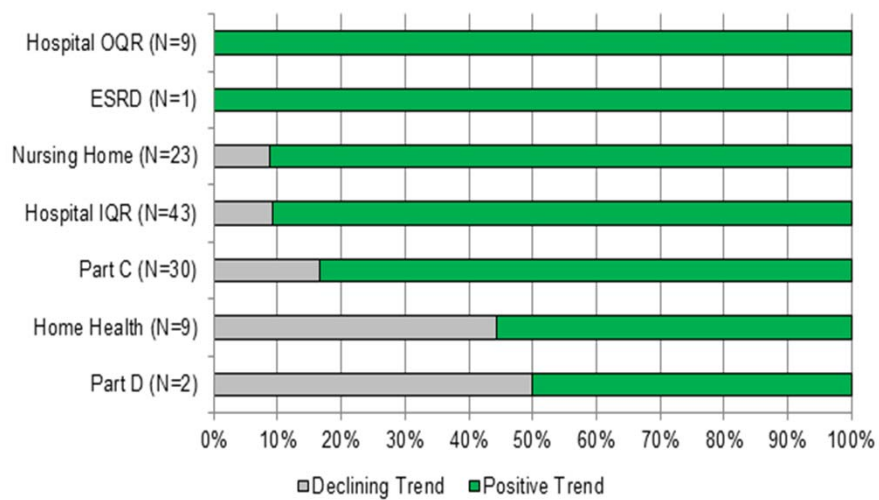
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Conclusions

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Change in Performance
2006-2010

Legend: Declining Trend, Positive Trend

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Overall Report Conclusions

- The majority of quality measures showed positive trends during the study period

- About 86 percent of the measures in these programs showed an actual increase or no change in the reported rates

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TEP Role: Scope and Objectives

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TEP Scope and Objectives

Review of TEP Charter

Purpose:

- To coordinate impact assessment activities across CMS quality reporting programs.

- To provide input on the development of an overall analytic plan and on potential future assessment activities.

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TEP Scope & Objectives

Background:

- First assessment of impact report was made publicly available on March 30, 2012.

- Subsequent reports are required to be made publicly available at least once every three years thereafter.

- CMS proposes to develop impact reports covering individual quality topics over the course of the next three years that will be summarized in a single review document to be made publicly available by March 1, 2015.

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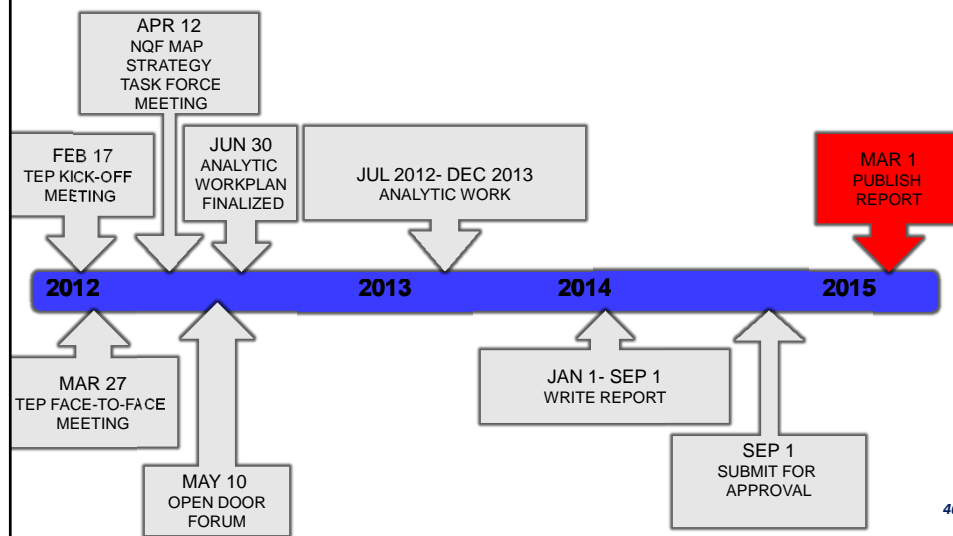
TEP Scope & Objectives

- Provide input on the short-term analytic plan (2012-2014) for assessing the impact of CMS quality measures implemented in quality programs
- Provide input on the long-term impact assessment activities (beyond 2014)
- Assess impact of the measures included in the pre-rulemaking process as well as the potential impact of non-implemented measures
- Other Issues related to quality measurement activities

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Timeline for 2015 Impact Assessment Report

Above timeline	
APR 12 NQF MAP STRATEGY TASK FORCE MEETING	
FEB 17 TEP KICK-OFF MEETING	JUN 30 ANALYTIC WORKPLAN FINALIZED	JUL 2012- DEC 2013 ANALYTIC WORK	MAR 1 PUBLISH REPORT

2012   **2013**   **2014**   **2015**

MAR 27 TEP FACE-TO-FACE MEETING

MAY 10 OPEN DOOR FORUM

JAN 1- SEP 1 WRITE REPORT

SEP 1 SUBMIT FOR APPROVAL

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Key Question Regarding Impact Assessment of Measures

How should we assess impact of measures?

- Based on the NQS priorities?
- Based on setting or program?
- Other?

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Key Question Regarding Impact Assessment of Measures

What exact impact should we assess?

- Impact on health outcomes
- Impact on populations
- Impact on cost of care for a condition, episode, etc.
- All of the Above?

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Key Question Regarding Impact Assessment of Measures

- Are there other considerations CMS should think about as it tries to define an approach to this evaluation or analytic plan?

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Send feedback/questions to:
MeasuresTEP@hsag.com

CMS National Impact Assessment

Website:

http://www.cms.gov/QualityMeasures/02_NationalImpactAssessment.asp

ACA 3014 assessment report on the CMS website

http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/QualityMeasurementImpactReports.html

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Quality Alliance Steering Committee: Environmental Scan

Ayodola Anise, MHS
Engelberg Center for Health Care Reform at Brookings

Quality Alliance
Steering Committee

Objectives of Presentation

- Provide background on need for environmental scan of performance measurement implementation efforts
- Discuss focus of environmental scan
- Discuss tasks and timeline
- Provide update on progress

Quality Alliance
Steering Committee

Background

- New challenges are arising as performance measurement implementation progresses (e.g., establishing processes for consistent aggregation of results across payers)
- QASC's experience positions it to address these challenges and make a significant impact on performance measurement implementation

Quality Alliance
Steering Committee

QASC Activity: Environmental Scan

- Develop a critical appraisal of the current environment:
  - Capture existing measurement implementation infrastructure at local, state, and Federal level
  - Review Federal initiatives that rely on performance measure implementation

Quality Alliance
Steering Committee

Goals of Environmental Scan

- Build on existing information and research on other activities related to performance measure implementation and use
- Identify gaps in implementation that QASC can address, including opportunities to do the following:
  – Build increasingly sophisticated multi-source measurement capabilities
  – Guide effective, value-directed changes in health care quality improvement, reporting, and financing

Quality Alliance
Steering Committee

Organizations to be Interviewed

- Implementation is taking place across many different settings
- Organizations to be interviewed will include the following:
  – Accountable care organizations
  – Regional collaboratives
  – States
  – Health plans
  – Qualified entities under section 10332

Quality Alliance
Steering Committee

Key Concepts to Address

- Engagement/partnerships
- Measures captured and rationale for selection
- IT systems and data sources
- Data aggregation
- Measure calculation
- Use and usefulness of measure results
- Financing reform/sustainability model
- Participation in Federal and regional programs and initiatives
- Successes and challenges in measure implementation
- Gaps in measure implementation

Quality Alliance
Steering Committee

Tasks and Timeline in 2012

- Select criteria for choosing organizations to participate in environmental scan (February–April)
- Develop key concepts to capture in interviews (February–April)
- Identify organizations and key staff to interview (March–April)
- Develop structured interview guides (March–May)
- Conduct interviews with organizations (May–July)
- Identify Federal measure programs (May–July)
- Analyze results (May–August)
- Develop report with synthesis of findings and identification of gaps (September)

Quality Alliance
Steering Committee

Role of QASC, Work Groups, and Others

- Provide input on organizations to interview, key concepts, and interview questions
- Provide input on interpreting findings from interviews
- Identify gaps in measure implementation
- Identify ways to leverage regional and other existing assets in support of Federal requirements
- Suggest areas where QASC's leadership would be most impactful

Quality Alliance
Steering Committee

Next Steps

- Integrate existing information and research on other activities related to performance measure implementation and use
- Finalize selection criteria, key concepts, and interview guides
- Identify organizations to interview

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Steering Committee

Evaluation

Performance Measurement

- What evaluation information is needed about measurement?
- What efforts are underway to assess the use and impact of measures?
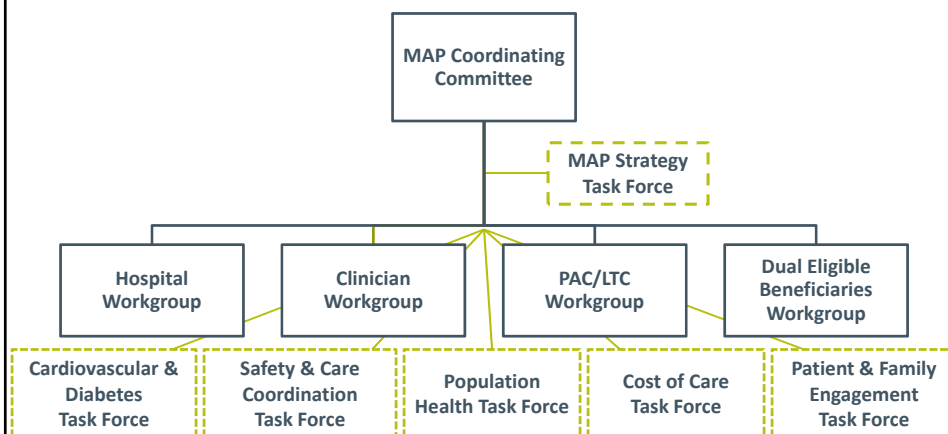
MAP

- How can MAP best leverage available information about measure use and impact? What should MAP's role be in gathering information about measure use and impact?
- How should success be defined for MAP? What indicators can be used to assess progress against MAP's goals?

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Proposed MAP Scope of Work for 2012-13

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Proposed MAP Work for 2012-13

- Enhance existing two-tiered structure with topic-focused task forces

- Identify families of measures for specific topics and core measure sets composed of available measures and gaps

- Provide pre-making input to HHS on measures under consideration for rulemaking

- Expand decision making support for pre-rulemaking activities

- Delve into measurement issues for dual eligible sub-populations

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Proposed MAP Structure

```
                    MAP Coordinating
                       Committee
                           |
                           |------ MAP Strategy
                           |        Task Force
        |----------|-------|-------|----------|
   Hospital    Clinician    PAC/LTC      Dual Eligible
   Workgroup   Workgroup   Workgroup     Beneficiaries
                                          Workgroup
```

| Cardiovascular & Diabetes Task Force | Safety & Care Coordination Task Force | Population Health Task Force | Cost of Care Task Force | Patient & Family Engagement Task Force |

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Proposed MAP Work for 2012-13:
Strategy Task Force

The charge of the MAP Strategy Task Force is to:

- Advise Coordinating Committee on a 3-year strategic plan for achieving aligned performance measurement that enables improvement, transparency, and value

- Establish an evaluation plan and metrics of success

- Further enhance MAP's guiding principles and Measure Selection Criteria

- Provide guidance on the development of families of topically-related measures and gap-filling pathways to support alignment across federal programs and public and private payers

- Deliverables:
  - Outline of approach due to HHS: June 1, 2012
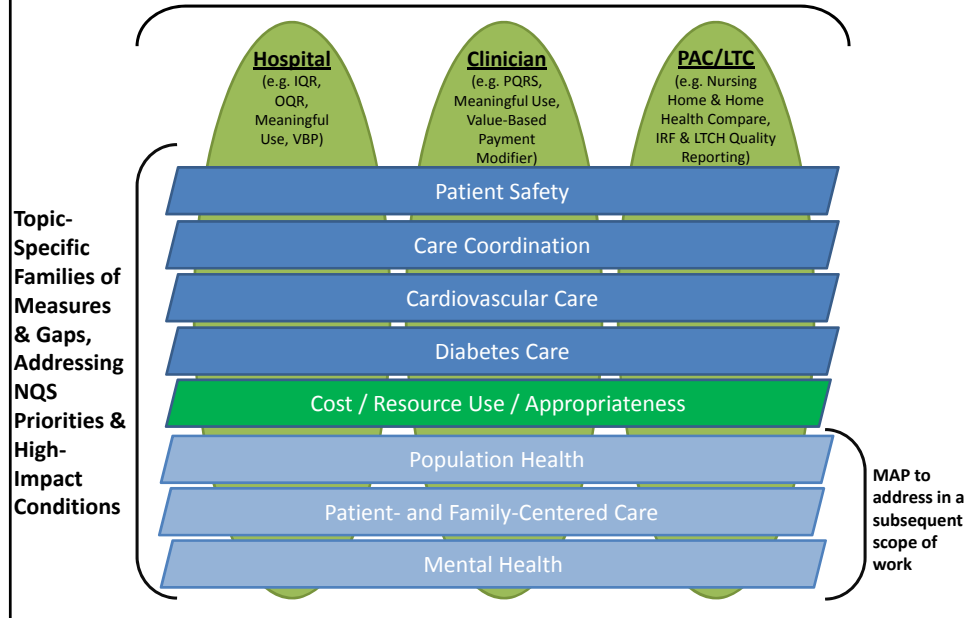 - Final report due to HHS: October 1, 2012

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Proposed MAP Work for 2012-13:
Families of Measures

Proposed families of measures for NQS priorities and high-impact conditions

- Families of measures identified by task forces
  - Task force membership drawn from existing MAP Coordinating Committee and workgroup membership to achieve balance and necessary expertise
  - Coordinating Committee oversees work of task forces
- Wave 1 – due to HHS October 1, 2012
  - Safety and Care Coordination + cost of care implications
  - Cardiovascular and Diabetes Care + cost of care implications
- Wave 2 – due to July 1, 2013
  - Cost of Care (e.g., total cost, resource use, appropriateness)
  - Population Health (e.g., prevention, key health behaviors, healthy lifestyles, and well- being)
  - Patient- and Family-Centered Care
  - Mental Health
- White papers commissioned to support the identification of issues and potential measures

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Proposed Families of Measures Illustration:

Core Measure Sets for Settings, Programs & Populations, Drawn from Families

Hospital
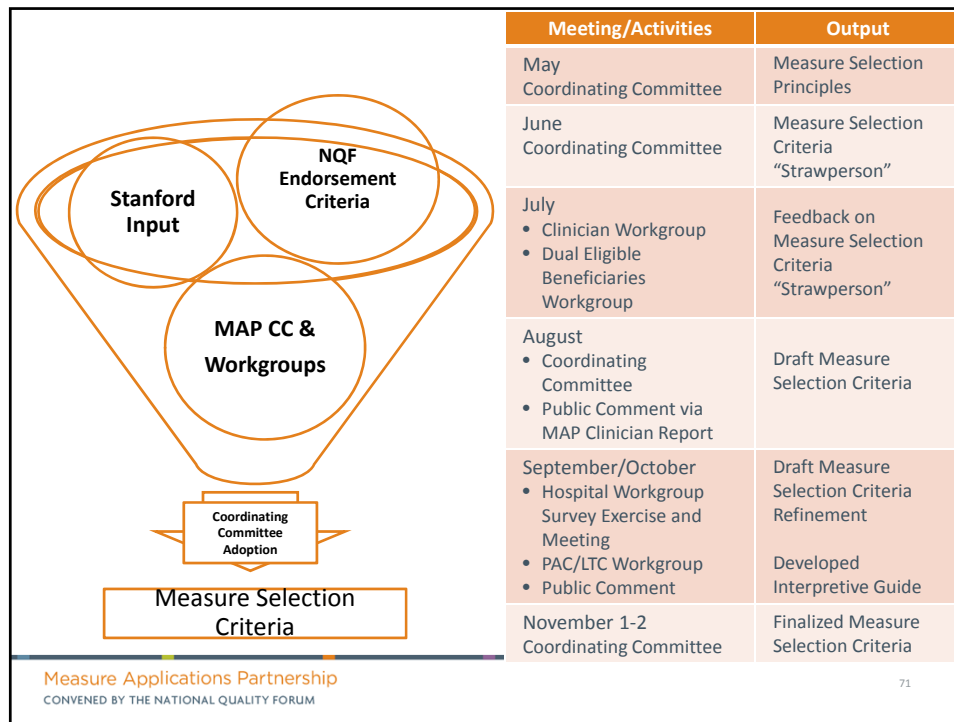(e.g. IQR, OQR, Meaningful Use, VBP)

Clinician
(e.g. PQRS, Meaningful Use, Value-Based Payment Modifier)

PAC/LTC
(e.g. Nursing Home & Home Health Compare, IRF & LTCH Quality Reporting)

Topic-Specific Families of Measures & Gaps, Addressing NQS Priorities & High-Impact Conditions

- Patient Safety
- Care Coordination
- Cardiovascular Care
- Diabetes Care
- Cost / Resource Use / Appropriateness
- Population Health
- Patient- and Family-Centered Care
- Mental Health

MAP to address in a subsequent scope of work

Proposed MAP Work for 2012-13: Key Deliverables

Proposed Deliverables	Proposed Date Due to HHS
Outline of Approach to MAP Strategic Plan	June 1, 2012

• MAP Strategic Plan for Aligning Performance Measurement
• Refined MAP Measure Selection Criteria and High-Impact Conditions
• Families of Measures:
  - Cardiovascular Health & Diabetes + cost of care implications
  - Safety & Care Coordination + cost of care implications
	October 1, 2012

MAP Pre-Rulemaking Input	February 1, 2013
• Cost of care (e.g., total cost, resource use, appropriateness) • Families of Measures: Population Health, Patient and Family Engagement, and Mental Health • Measures for High-Need Sub-Populations of Dual Eligible Beneficiaries	July 1, 2013

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Proposed MAP Work for 2012-13: Discussion

- How does the proposed MAP 2012 scope of work address the goals of the 3-year strategic plan?

- How do we ensure the task force work reflects the broader strategy, given that both will be developing simultaneously?

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Enhancing MAP's Measure Selection Criteria

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Meeting/Activities	Output
May Coordinating Committee	Measure Selection Principles
June Coordinating Committee	Measure Selection Criteria "Strawperson"
July • Clinician Workgroup • Dual Eligible Beneficiaries Workgroup	Feedback on Measure Selection Criteria "Strawperson"
August • Coordinating Committee • Public Comment via MAP Clinician Report	Draft Measure Selection Criteria
September/October • Hospital Workgroup Survey Exercise and Meeting • PAC/LTC Workgroup • Public Comment	Draft Measure Selection Criteria Refinement Developed Interpretive Guide
November 1-2 Coordinating Committee	Finalized Measure Selection Criteria

Within the diagram: Stanford Input; NQF Endorsement Criteria; MAP CC & Workgroups; Coordinating Committee Adoption; Measure Selection Criteria

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MAP Measure Selection Criteria

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

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

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

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

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MAP Measure Selection Criteria

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

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

7. Program measure set includes considerations for healthcare disparities

8. Program measure set promotes parsimony

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MAP-NPP Relationship

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NPP's Proposed Scope of Work for 2012

NPP's Consultative Role	NPP Action Pathways	Partnership for Patients Quarterly Summits	Partnership for Patients Affinity Groups and Action Registry Reports
• Currently in discussion with HHS regarding NPP's ongoing role in providing input to the Secretary of HHS on the National Quality Strategy	• Action pathway development and Implementation • Maternity action pathway emphasizing elective deliveries and cesarean section • (Re)admissions action pathway emphasizing care across the continuum that addresses the needs of vulnerable populations • Template for NPP approach to action pathway development	• Quarterly PfP safety summits for up to 200 participants, including NPP Partners, PfP stakeholders, partners, contractors • Accelerate progress towards achievement of the PfP goals through collaborative public-private sector efforts and actions • Provide a forum for affinity groups to identify obstacles, barriers, and solutions to reducing readmissions and healthcare-acquired conditions.	• Convene 4 cross-cutting affinity groups (e.g., rural health, patient and family engagement, clinician engagement) • Webinars to address affinity group challenges and opportunities • Content input into HHS web portal • Action registry for tracking and monitoring action commitments, including NPP action teams and affinity groups inputs

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Promoting Bi-Directional Communication and Integration between NPP and MAP

- Periodic meetings of the MAP Strategy Task Force to continue bi-directional dialogue and assess progress

- NPP representation on MAP Task Forces identifying families of measures

- Engagement of MAP in NPP action catalyst work

- Other mechanisms to promote further integration across our work?

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Ensuring NPP-MAP Alignment

- MAP 3-year goals focus on performance measurement for improvement, transparency, and value
  - In addition to performance measurement, how can NPP coordinate with MAP on other action steps to advance quality improvement, public reporting, and value-based purchasing?

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Ensuring NPP-MAP Alignment

- MAP will be identifying families of measures, initially targeting patient safety, care coordination, cardiovascular care, and diabetes care
  - How do we integrate NPP action pathways targeting maternity care and readmissions so that the families of measures will reinforce this work?
  - For the disease-specific areas, how do we integrate clinical, behavioral, and social environmental measures that align with NPP input to the NQS goals?
  - How do we ensure families of measures capture harm due to overuse as an important component of safety, as NPP recommended to HHS?

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Opportunity for Public Comment

Summary and Next Steps

MAP Strategy Task Force: Next Steps

- Strategy Task Force Review Draft Approach to the Strategic Plan

- Coordinating Committee Review Draft Approach to the Strategic Plan
  - Web Meeting to Present Approach- *Target Dates: Week of May 7-11, 2012*
  - Web Meeting to Discuss Approach- *Target Dates: Week of May 14-18, 2012*

- Strategy Task Force Review Final Approach to the Strategic Plan

- Submit Approach to Strategic Plan to HHS June 1, 2012

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PRIORITIES FOR THE
NATIONAL QUALITY STRATEGY

EXECUTIVE SUMMARY ONLY - CLICK HERE FOR FULL REPROT

EXECUTIVE SUMMARY

In 2010, the Affordable Care Act (ACA) charged the Department of Health and Human Services (HHS) with developing a National Quality Strategy (NQS) to better meet the promise of providing all Americans with access to healthcare that is safe, effective, and affordable. Legislation required the NQS be shaped by input from stakeholders wielding collective national influence to ensure a nationally achievable, impact-oriented strategy. As a result, The National Quality Forum (NQF) convened the multistakeholder National Priorities Partnership (NPP), a partnership of 48 public- and private-sector partners, to provide collective input to HHS for consideration as it developed this national body of work.

The Secretary of HHS released the NQS in March 2011, strongly inclusive of NPP's input. Upon its release, NQS authors noted the need for further refinement—specifically around goals, measures, and public- and-private sector paths to implementation and improvement; subsequently HHS again requested input from NPP to help make the NQS more actionable and measurable. This report is in response to HHS's request for input on specific goals and measures for each of the six NQS priorities and highest-value strategic opportunities that can accelerate achievement of the three NQS aims of better care, affordable care, and healthy people and communities.

The term "alignment" is prevalent in this report. Stated plainly, enormous opportunity exists to make things simpler, more efficient, and less expensive. There are several major and specific opportunities for greater alignment that will help make significant gains in health, healthcare, and affordability:

- We all can focus on the same set of priorities and goals laid out in the NQS. No one can fix everything at once, and the imperative exists now for the public and private sectors to row in the same direction, at the same time, for shared and important gains in improving health, healthcare, and affordability in the United States—while still preserving the necessary flexibility on approach to meeting those aims.

- We can recognize that the key to health and well-being begins long before an individual enters the healthcare system and identify ways to collaborate within communities to accelerate progress on healthy behaviors and social determinants as contributors to health.

- We all can use the same data platforms, measures, and public reporting of performance. The current environment of measuring and reporting creates and proliferates use of multiple systems, measures, forms, and reports that create undue burden on providers, confusion to consumers, and cost to the nation.

- We can send unified signals to the market about incentives and rewards. Doing so would create a clear sense of direction and eliminate the confusion that currently creates expensive and often burdensome activity but not necessarily greater value or improvement.

- We can take great strides now to find places where both the public and private sectors can make gains individually and in partnership, and along the way, remove fragmentation and complexity that unnecessarily impair the effectiveness and safety of our healthcare and impede our ability to improve health.

Strategic Opportunities for Accelerating Improvement

There are three categories of strategic opportunities critical for making progress toward achieving the three NQS aims. These may serve not only as a catalyst for HHS, but also as a call to all stakeholders to identify opportunities for action and alignment, engage others to advance the priorities and goals, and accelerate change. These opportunities will require action at many levels and strong public-private partnerships to encourage adoption of shared goals, engender shared accountability, and promote ongoing multistakeholder collaboration. As an immediate next step, the strategic opportunities will need detailed pathways identifying practical steps for implementation to achieve better health and a more accountable, high-value healthcare system.

1. There must be a national strategy for data collection, measurement, and reporting that supports performance measurement and improvement efforts of public- and private-sector stakeholders at the national and community level.

Alignment and support of national, state, and community improvement efforts requires a solid infrastructure for collecting data and for analyzing and reporting performance. This infrastructure should include three components:

- ensuring a common data platform in every community that includes the necessary person-level data (covering all-payers and the uninsured) to calculate core sets of measures along with community-level data on population health and social determinants of health;

- identifying core sets of standardized performance measures applicable to each of the national priorities and goals; and

- implementing robust reporting programs that allow communities, states, and the nation to gauge progress in meeting the NQS priorities and goals.

The absence of these components seriously hampers efforts to achieve the NQS, to gauge progress, and to establish systems of accountability. Continued proliferation of program- and payer-specific data collection and measurement efforts, although well-intentioned, will continue to contribute to a source of significant administrative burden and lead to confusion and frustration at the provider level. A strategic plan, roadmap, and timeline for establishing this national and community-level infrastructure should be accelerated to allow for rapid implementation over the next five years.

It is critical that all federal programs drive toward the establishment of a common platform for measuring and reporting and make full use of this platform once established. As an example, a measurement pathway would lay out steps to move from measures calculated with all-payer, administrative data to those using clinical registries and electronic health records (EHRs); more sophisticated measures would require patient-reported data followed by the use of health information exchanges to support longitudinal measurement of care coordination and patient-reported outcomes. Public- and private-sector initiatives and programs focused on healthcare quality should incorporate the NQS core measures as part of their reporting mechanism and program evaluation for further harmonization.

2. There must be an infrastructure at the community level that assumes responsibility for improvement efforts, resources for communities to benchmark and compare performance, and mechanisms to identify, share, and evaluate progress.

The national imperative to improve the health of populations requires significant investment in infrastructure at the community level to address social determinants—a key factor in improving health—and to sponsor multisector efforts to create healthier communities. Toward this end, communities will need assistance in:

- establishing public-private, multistakeholder partnerships to provide leadership and assume responsibility for achieving the NQS priorities and goals; and

- identifying a compendium of intervention strategies, models, and best practices for each of the six NQS priority areas to allow community leaders to benchmark, share, and learn from each other.

Recognizing that communities vary in their states of readiness, the priorities and goals presented in this report offer a menu of options that should resonate regardless of where they fall on the implementation spectrum. Regardless of their level of experience, communities should receive support to identify priority areas, implement programs, and assess and report on progress to achieve success; the federal government can provide leadership to ensure that these resources are available to communities to identify priority areas and develop individualized strategies for improving quality at the local level.

3. There must be ongoing payment and delivery system reform—emphasizing primary care—that rewards value over volume; promotes patient-centered outcomes, efficiency, and appropriate care; and seeks to improve quality while reducing or eliminating waste from the system.

Changing incentives and improving care delivery models are critical to improving health and healthcare and to

encouraging the development of a system that supports affordable, high-quality care. Strategic opportunities in this area include:

- rapidly designing and implementing new payment programs and care delivery models emphasizing shared learning and public and private stakeholder collaboration;

- addressing underlying cost drivers that affect payment and delivery models;

- ensuring transparency to promote informed decision making as an integral component of all payment and delivery models; and

- addressing underlying workforce and technology constraints that impede progress.

Healthcare has entered a period of extraordinary innovation, with public and private purchasers and health plans working to identify payment programs that reward value and encourage integrated and coordinated delivery models. Public- and private-sector stakeholders should establish a mechanism to build and share evidence of approaches that work best, identify core sets of measures on patient outcomes and cost to be used across all payment and delivery programs, and encourage the adoption and alignment of payment programs around a common measurement strategy.

Importantly, targeted payment reforms are critical to addressing underlying cost drivers, including overuse and inappropriate care. Efforts should be made to further develop the evidence base on these drivers and identify specific strategies to target areas of high-cost, high-variation care.

Consumers, purchasers, health plans, and others must have the necessary quality and cost data to select from a variety of providers and services. Ensuring transparency of these data is critical to making well-informed decisions. As accountable care organizations and other integrated structures become more widespread, monitoring the data for unintended consequences such as market concentration and cost shifting will become increasingly important to determine whether payment and delivery models are achieving their goals or exacerbating existing problems.

Proposed Goals and Measures

HHS requested specific goals and accompanying measures for each of the six NQS priority areas. The measures are at the population/national level and set the stage for a cascade of subsequent measures (including those at the provider and clinician level) that establish accountability for all who can make progress against the NQS. This report proposes goals that are broad in nature but can be put into operation through specific measurement strategies. Many of the illustrative measures already are reported at the national level through various reporting programs; but where gaps exist, the report suggests measures that might be developed or adapted for use at the national level.

Summary of NPP's Proposed Goals and Measure Concepts

National Priority: Work with communities to promote wide use of best practices to enable healthy living and well-being.		
GOALS	Promote healthy living and well-being through community interventions that result in improvement of social, economic, and environmental factors.	**Measure Concepts** • Adequate social support • Emergency department visits for injuries • Healthy behavior index • Binge drinking • Obesity • Mental health • Dental caries and untreated dental decay • Use of the oral health system • Immunizations
	Promote healthy living and well-being through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.	
	Promote healthy living and well-being through receipt of effective clinical preventive services across the lifespan in clinical and community settings.	

National Priority: Promote the most effective prevention, treatment, and intervention practices for the leading causes of mortality, starting with cardiovascular disease.		
GOALS	Promote cardiovascular health through community interventions that result in improvement of social, economic, and environmental factors.	**Measure Concepts** • Access to healthy foods • Access to recreational facilities • Use of tobacco products by adults and adolescents • Consumption of calories from fats and sugars • Control of high blood pressure • Control of high cholesterol
	Promote cardiovascular health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.	
	Promote cardiovascular health through receipt of effective clinical preventive services across the lifespan in clinical and community settings.	

National Priority: Ensure person- and family-centered care.		
GOALS	Improve patient, family, and caregiver experience of care related to quality, safety, and access across settings.	**Measure Concepts** • Patient and family experience of quality, safety, and access • Patient and family involvement in decisions about healthcare • Joint development of treatment goals and longitudinal plans of care • Confidence in managing chronic conditions • Easy-to-understand instructions to manage conditions
	In partnership with patients, families, and caregivers—and using a shared decision-making process—develop culturally sensitive and understandable care plans.	
	Enable patients and their families and caregivers to navigate, coordinate, and manage their care appropriately and effectively.	

National Priority: Make care safer.		
GOALS	Reduce preventable hospital admissions and readmissions.	**Measure Concepts** • Hospital admissions for ambulatory-sensitive conditions • All-cause hospital readmission index • All-cause healthcare-associated conditions • Individual healthcare-associated conditions • Inappropriate medication use and polypharmacy • Inappropriate maternity care • Unnecessary imaging
	Reduce the incidence of adverse healthcare-associated conditions.	
	Reduce harm from inappropriate or unnecessary care.	

Summary of NPP's Proposed Goals and Measure Concepts *(continued)*

National Priority: Promote effective communication and care coordination.		
GOALS	Improve the quality of care transitions and communications across care settings.	**Measure Concepts** • Experience of care transitions
		• Complete transition records
		• Chronic disease control
	Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.	• Care consistent with end-of-life wishes
		• Experience of bereaved family members
		• Care for vulnerable populations
		• Community health outcomes
	Establish shared accountability and integration of communities and healthcare systems to improve quality of care and reduce health disparities.	• Shared information and accountability for effective care coordination

National Priority: Make quality care affordable for people, families, employers, and governments		
GOALS	Ensure affordable and accessible high-quality healthcare for people, families, employers, and governments.	**Measure Concepts** • Consumer affordability index
		• Consistent insurance coverage
		• Inability to obtain needed care
		• National/state/local per capita healthcare expenditures
	Reduce total national healthcare costs per capita by 5 percent and limit the increase in healthcare costs to no more than 1 percent above the consumer price index without compromising quality or access.	• Average annual percentage growth in healthcare expenditures
		• Menu of measures of unwarranted variation of overuse, including:
		- Unwarranted diagnostic/medical/surgical procedures
		- Inappropriate/unwanted nonpalliative services at end of life
	Support and enable communities to ensure accessible, high-quality care while reducing unnecessary costs.	- Cesarean section among low-risk women
		- Preventable emergency department visits and hospitalizations

By developing the NQS, HHS has laid a foundation for a shared accountability and action that can be accomplished only through robust, multistakeholder public-private partnerships that align, focus, and coordinate efforts and resources. The federal government itself has an enormous opportunity to examine its own efforts closely to support a unified data platform, core measure sets, active public reporting on priorities and goals, and incentives to fully unleash its power as a catalyst for change.

The National Priorities Partnership thanks HHS for the opportunity to provide input on further refinements to the NQS goals and measures and to suggest strategic opportunities that will accelerate achievement of national priorities to improve health and healthcare. With healthcare reform under way, the existence of shared goals will lead us in the right direction. Now is the time to accelerate the development of infrastructure and tools, the allocation of resources, and the dedication of our collective energy to achieve these goals.

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

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

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

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

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

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

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

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

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

NQS priority is adequately addressed in the program measure set

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

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

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

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

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

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

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

Subcriterion 4.1   Program measure set is applicable to the program's intended care setting(s)

Subcriterion 4.2   Program measure set is applicable to the program's intended level(s) of analysis

Subcriterion 4.3   Program measure set is applicable to the program's population(s)

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

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

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

Subcriterion 5.1   Outcome measures are adequately represented in the program measure set

Subcriterion 5.2   Process measures are adequately represented in the program measure set

Subcriterion 5.3   Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)

Subcriterion 5.4   Cost/resource use/appropriateness measures are adequately represented in the program measure set

Subcriterion 5.5   Structural measures and measures of access are represented in the program measure set when appropriate

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

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

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

Subcriterion 6.1   Measures within the program measure set are applicable across relevant providers

Subcriterion 6.2   Measures within the program measure set are applicable across relevant settings

Subcriterion 6.3   Program measure set adequately measures patient care across time

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

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

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

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

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

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

8. Program measure set promotes parsimony

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

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

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

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

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

Table 1: National Quality Strategy Priorities

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

Table 2: High-Impact Conditions:

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

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

MAP "WORKING" MEASURE SELECTION CRITERIA INTERPRETIVE GUIDE

NATIONAL QUALITY FORUM

Instructions for applying the measure selection criteria:

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

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

FOR CRITERION 1 – NQF ENDORSEMENT:

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

1. **'Importance to measure and report"**–how well the measure addresses a specific national health goal/ priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;

2. **'Scientific acceptability of the measurement properties'** – evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.

3. **'Usability'-** the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.

4. **'Feasibility'** – the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

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

• the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use

• whether the scope of the project/measure set is relatively narrow

• time-sensitive legislative/regulatory mandate for the measure(s)

• Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges

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

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

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

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

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

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

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

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.

- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.

- **Populations include:** Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

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

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

1. **Outcome measures** – Clinical outcome measures reflect the actual results of care.[1] Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[2]

2. **Process measures –** Process denotes what is actually done in giving and receiving care.[3] NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[4] Experience of care measures—Defined as patients' perspective on their care.[5]

3. **Cost/resource use/appropriateness measures** –

    a. Cost measures – Total cost of care.

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

    c. Appropriateness measures – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[7]

4. **Structure measures** – Reflect the conditions in which providers care for patients.[8] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FOR CRITERION 8 – PROGRAM MEASURE SET PROMOTES PARSIMONY:

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

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

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

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

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