NQF
National Quality Forum

Measure Applications Partnership Coordinating Committee

In-Person Meeting #1

May 3-4, 2011
9:00 am – 5:00 pm EST

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Coordinating Committee Roster

Tab 1

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Coordinating Committee

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

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

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

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Karen Milgate, MPP
Health Resources and Services Administration (HRSA)	Victor Freeman, MD, MPP
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Thomas Tsang, MD, MPH

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

Coordinating Committee Charge

Tab 2

Measure Applications Partnership
Coordinating Committee Charge

Purpose

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. The Coordinating Committee will also advise HHS on the coordination of performance measurement strategies across public sector programs, across settings of care, and across public and private payers.

The Coordinating Committee will set the strategy for the two-tiered Partnership and give direction to, and ensure alignment among, the MAP advisory workgroups. The workgroups will not give input directly to HHS; rather, they will advise the Coordinating Committee on measures needed for specific uses.

The work of the Coordinating Committee and input to HHS will be aligned with the HHS National Quality Strategy, as well as the related National Prevention and Health Promotion Strategy and National Patient Safety Initiative. The Committee's decision making framework will also consider high priority conditions and the patient-focused episode of care model. The Committee will adopt a set of measure selection criteria to guide its decisions. Explicit consideration will be given to performance measures needed for dual eligible beneficiaries in all of the MAP's work.

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

Tasks

The Coordinating Committee will set the strategy for the MAP; give direction to the advisory workgroups; ensure alignment of performance measurement across settings; and provide input to HHS through the following tasks:

1. Set a decision making framework, including measure selection criteria.
2. Identify charges for each workgroup.
3. Provide input to HHS on:
    a. Measures to be implemented through the federal rulemaking process, based on an overview of the quality problems in hospital, clinician office, and post-acute/long-term care settings, the manner in which those problems could be improved, and the related measures for encouraging improvement;
    b. A coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers;
    c. A coordination strategy for clinician performance measurement across public programs;

   d. Identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries;
   e. A coordination strategy for performance measurement across post-acute care and long-term care programs;
   f. Identification of measures for use in performance measurement for hospice programs and facilities; and
   g. Identification of measures for use in performance measurement for PPS-exempt cancer hospitals.
4. Identification of critical measure development and endorsement gaps.

Timeframe

The first phase of this work will begin in March 2011 and will be completed by June 2012.

Membership

Attachment A contains the MAP Coordinating Committee 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.

Procedures

Attachment B contains the MAP member responsibilities and operating procedures.

MAP Workgroups Roster

Tab 3

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	Dick Salmon, MD, PhD
Consumers' CHECKBOOK	Robert Krughoff, JD
Unite Here Health	Elizabeth Gilbertson, MS
Kaiser Permanente	Amy Compton-Phillips, MD
Minnesota Community Measurement	Beth Averbeck, MD
Physician Consortium for Performance Improvement	Mark Metersky, MD
The Alliance	Cheryl DeMars, MSSW

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

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

George J. Isham, MD, MS

Elizabeth A. McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Dual Eligible Beneficiaries Workgroup

Chair (voting)
Alice Lind, MPH, BSN

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

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

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

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

George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the Hospital Workgroup

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

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

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

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Mamatha Pancholi, MS
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Pamela Cipriano, PhD, RN NEA-BC, FAAN
Veterans Health Administration (VHA)	Michael Kelley, MD

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

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

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

Chair (voting)

Carol Raphael, MPA

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

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

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)	Judy Sangl, ScD
Centers for Medicare & Medicaid Services (CMS)	Shari Ling, MD
Veterans Health Administration (VHA)	Scott Shreve, MD

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 Ad Hoc Safety Workgroup

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

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

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

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Mamatha Pancholi, MS
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD., CPC-A
Office of the National Coordinator for HIT (ONC)	Pamela Cipriano, PhD, RN NEA-BC, FAAN

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

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

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

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

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

MAP Schedule of Deliverables

Tab 4

Measure Applications Partnership - Schedule of Deliverables

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

Draft MAP Timeline

Tab 5

HHS Task 15 - Timeline by Group -- REVISED March 22

DRAFT

Group	2011									2012					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	April 8 - 2 hr web meeting	May 3 -4 - 2 day in-person meeting: big picture planning, charge for workgroups, framework (May 13 - 2 hr ALL MAP optional attendance at group web meeting)	June 21-22 - 2 day in-person meeting, clinician- coordination strategy, dual's interim report, framework	July 27 or Aug 5 - 2 hr web meeting	Aug 16-17 or 17-18 - 2 day in-person meeting, HACs and readmissions, finalize WG input for September reports, begin work on quality issues in 11 settings		Oct 18 - 2hr public webinar to update on all tasks Oct 19 - 2 hr web meeting	Nov 1-2 - 2 day in-person meeting, finalize PAC report, finalize quality issues in 11 settings	Dec 8 or 9 - ALL MAP groups on 2 hr web meeting to distribute measures with homework	Jan 3-6 - 2-day in-person meeting to finalize pre-rulemaking input 1-2 week public comment period	**REPORT Feb 1st 15.1** Feb 6-7 - informational public webinar Feb 28-29 - 2 hr web meeting	March 14-16 - 2 day in-person meeting, finalize input on June reports		
Clinician Workgroup Coordination of measures for physician performance improvement (15.2a), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		May 13 - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework Mid-May - 2 day in-person meeting, framework, strategy for coordination of physician measurement, HACs & readmissions	Late June - 2 hr web meeting	July - 2 day in-person meeting to finalize strategy and themes for report on physician performance measurement, HACs & readmissions	late Aug - 2 week public comment period for physician strategy and HACs/readmissions	**REPORT Sept 30th 15.2a**	Oct 18 - 2hr public webinar to update on all tasks		Dec 8 or 9 - ALL MAP groups on 2 hr web meeting to distribute measures with homework Dec 12 or 13 - 1 day in-person meeting to react to proposed measures						
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)		May 13 - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework					Oct 18 - 2hr public webinar to update on all tasks Oct 17-19 - 2 hr web meeting	Nov 2-4 - 1 day in-person meeting to discuss and finalize measures for cancer hospitals	Dec 8 or 9 - ALL MAP groups on 2 hr web meeting to distribute measures with homework Dec 14 or 15 - 1 day in-person meeting to react to proposed measures				beginning April 2: webinar and 30 day comment period on draft cancer report	**REPORT June 1st 15.2c**	
Ad Hoc Workgroup HACs & readmissions (15.4)		May 13 - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	June 9-13 - 2 day in-person meeting with additional payers, consider HACs & readmissions, framework	July 11-14 - 1 day in-person meeting, review other groups' work on HACs and readmissions to finalize report on HACs & readmissions	late Aug - 2 week public comment period for physician strategy and HACs/readmissions	**REPORT Sept 30th 15.4**	Oct 18 - 2hr public webinar to update on all tasks								

Measures published **by CMS on December 1**

* All dates are tentative

HHS Task 15 - Timeline by Group -- REVISED March 22

DRAFT

Group	2011									2012					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Dual Eligible Beneficiaries Workgroup Identify quality issues specific to duals and appropriate measures and measure concepts (15.3); some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		May 13 - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework Week of May 23 - 2 day in-person meeting to discuss duals' quality issues, HACs & readmissions, framework		July 5-8 - 2 hr web meeting July 18-19 - 2 day in-person meeting to continue discussion of quality issues, finalize preliminary themes, HACs & readmissions		**Interim REPORT Sept 30th 15.3**	Oct 18 - 2hr public webinar to update on all tasks 30-day comment period on interim report	Nov 15-17 - 1 day in-person meeting, present public and HHS feedback, begin next phase	Measures published **by CMS on December 1** Dec 8 or 9 - ALL groups on 2 hr web meeting to distribute measures with homework Dec 15 or 16 - 2 hr web meeting to react to proposed measures	Jan 23-25 - 2 hr web meeting	Feb 13-16 - 2 day in-person meeting to finalize measure concepts and themes for report		beginning April 2: webinar and 30 day comment period on draft duals report		**REPORT June 1st 15.3**
PAC/LTC Workgroup Measures and coordination for Medicare PAC programs (15.2b), measures for hospice care (15.2d), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		May 13 - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	June 27-30 - 1 day in-person meeting, consider HACs & readmissions, framework		early to mid August - 2 hr web meeting mid to late August - 2 day in-person meeting to discuss measures for PAC and coordination strategy		Oct 18 - 2hr public webinar to update on all tasks	late Nov through late Dec - 30 day public comment period on PAC report and public webinar to introduce public comment on PAC report	Dec 8 or 9 - ALL MAP groups on 2 hr web meeting to distribute measures with homework Dec 13 or 14 - 1 day in-person meeting to react to proposed measures		**REPORT Feb 1st 15.2b** Feb 8-10 - 2 hr web meeting Feb 21-23 - 2 day in-person meeting to finalize measures for hospice		beginning April 2: public webinar and 30 day comment period on draft hospice report		**REPORT June 1st 15.2d**

* All dates are tentative

List of Measures Criteria

Tab 6

NQF Measure Selection Criteria Project

List of Measures Criteria Collected as of April 19, 2011

SOURCE / RESEARCHER	CRITERIA NAME	STAKEHOLDER AFFILIATION
AARP*		Consumer
Agency for Healthcare Research and Quality (AHRQ)	Guide to Prevention Quality Indicators (2006)	Federal Gov't
Agency for Healthcare Research and Quality (AHRQ)	Selecting Quality and Resource Use Measures: A Decision Guide for Community Quality Collaboratives (2010)	Federal Gov't
America's Health Insurance Plans (AHIP)*		Health Plan
Aligning Forces for Quality (AF4Q)	Lessons Learned in Public Reporting: Deciding What to Report (2011)	Multi-stakeholder
American College of Cardiology (ACC)	Health Policy Statement on Principles for Public Reporting of Physician Performance Data (2008)	Provider
American Society of Thoracic Surgeons	Quality Measurement in Adult Cardiac Surgery: Conceptual Framework and Measure Selection (2007)	Provider
AQA Alliance	Principles for Public Reports on Healthcare (2006)	Multi-stakeholder
AQA Alliance	Principles for Reporting to Clinicians and Hospitals (2006)	Multi-stakeholder
AQA Alliance	Parameters for Selecting Measures for Physician and Other Clinican Performance (2009)	Multi-stakeholder
Blue Cross Blue Shield of Massachusetts	Guiding Principles in Selecting Performance Measures for “High Stakes”Purposes	Health Plan
CHART	Measure Prioritization and Inclusion Criteria (2008)	Multi-stakeholder
CMS Fee-for-Service Program	Roadmap for Quality Measurement in the Traditional Medicare Fee-for-Service Program (2009)	Purchaser
CMS Better Quality Information for Medicare Beneficiaries Project	Guiding Principles in Selecting Performance Measures for “High Stakes”Purposes	Purchaser
CMS Medicare Advantage*	Critera for Plan Star Ratings	Purchaser
CMS Office of Dual Eligibles*		Purchaser
CMS Meaningful Use Program	Meaningful Use Objective Criteria (2010)	Purchaser
Consumer Purchaser Disclosure Project	Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs (2008)	Consumer/ Purchaser
Consumer Purchaser Disclosure Project	Consumer & Purchaser Criteria for a Robust Provider-Level Performance Measure Set (2010)	Consumer/ Purchaser
Consumers Union*		Consumer

Hibbard, Judith	Criteria for Patient-Generated Performance Measures	Consumer / Academic
Hospital Quality Alliance (HQA)	HQA Criteria For Assessing NQF-Endorsed Measures for Adoption and Prioritization (2009)	Multi-stakeholder
Integrated Healthcare Association (IHA)	P4P Criteria for Choosing Future Clinical Measures (2008)	Multi-stakeholder / Payer
Integrated Healthcare Association (IHA)	P4P Guiding Principles (2006)	Multi-stakeholder / Payer
Institute of Medicine (IOM)	Envisioning the National Health Care Quality Report (2001)	Research
Institute of Medicine (IOM)	Future Directions for the National Healthcare Quality and Disparities Reports (2010)	Research
Institute of Medicine (IOM)	Performance Measurement Accelerating Improvement (2006)	Research
Joint Commission	Accountability Measures Using Measurement to Promote Quality Improvement (2010 Editorial)	Provider / Accreditation
Joint Commission	Attributes of Core Performance Measures and Associated Evaluation Criteria	Provider / Accreditation
Leapfrog Group	Criteria for Leaps and Measures (2008)	Purchaser
Massachusetts Health Quality Partners	MHQP Policy Statement on the Public Release of Health Care Performance Data (2005)	Multi-stakeholder
McGlynn, Elizabeth	Selecting Common Measures of Quality and System Performance (2003)	Consumer / Academic
National Quality Forum	Measure Evaluation Criteria (2011)	Multi-stakeholder
National Quality Forum / Gretsky Group	Identification of Potential 2013 e-Quality Measures (2010)	Multi-stakeholder
National Committee for Quality Assurance (NCQA)	HEDIS criteria	Accreditation
National Institute for Health and Clinical Excellence (NICE)*		International Gov't
Physician Consortium for Performance Improvement (PCPI)	Measure Testing Protocol (2010), Evidence-based statement and workgroup charge	Provider
RAND	Payment Reform: Analysis of Models and Perf. Meas. Implications (2011)	Research
Society of Behavioral Medicine Health Policy Committee	Criteria for selecting patient report EHR measures (2011)	Multi-stakeholder
Veterans Health Administration	Performance Indicators Guide	Provider / Federal Gov't
Wenger, Neil*	Criteria for ACOVE measures	Consumer / Academic

* Indicates that gathering of criteria from this organization is in process

Member Responsibilities

Tab 7

NQF
NATIONAL QUALITY FORUM

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.

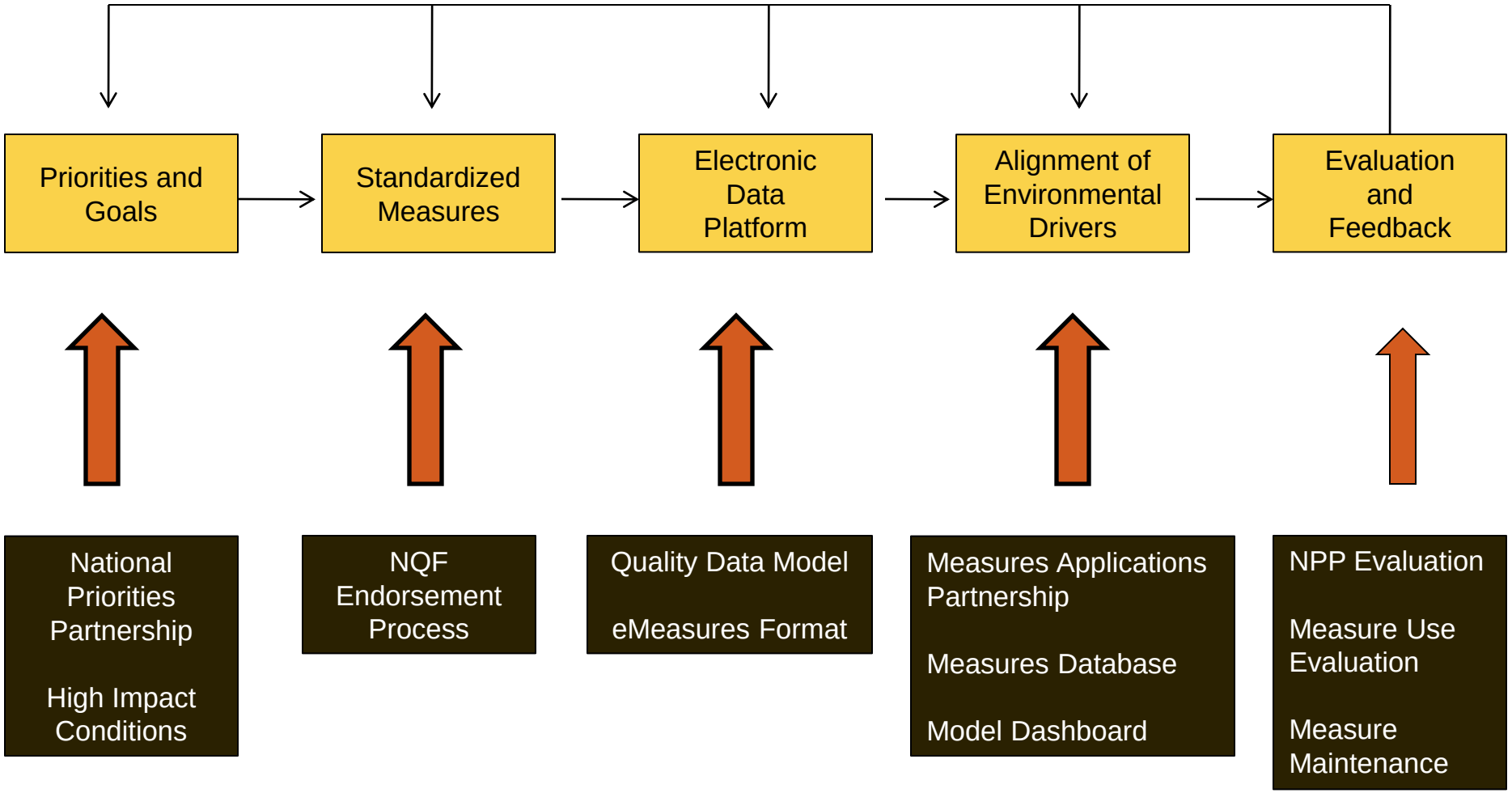
Adopted by the NQF Board of Directors on September 23, 2010

Quality Measurement Enterprise Powerpoint Slide

Tab 8

Quality Measurement Enterprise

NQF
National Quality Forum



NQF Endorsement Process: Evaluation Criteria Powerpoint Slides

Tab 9

NQF Endorsement Process Evaluation Criteria

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National Quality Forum

MAP Coordinating Committee
May 3, 2011

NQF Evaluation Criteria

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- **Importance to measure and report**
  - What is the level of evidence for the measure focus?
  - Is there an opportunity for improvement?
  - Relation to a priority area or high impact area of care?
- **Scientific acceptability of the measurement properties**
  - What is the reliability and validity of the measure?
- **Usability**
  - Are the measure results meaningful and understandable to intended audiences and useful for both public reporting and informing quality improvement?
- **Feasibility**
  - Can the measure be implemented without undue burden, capture with electronic data/EHRs?
- **Comparison to related or competing measures**

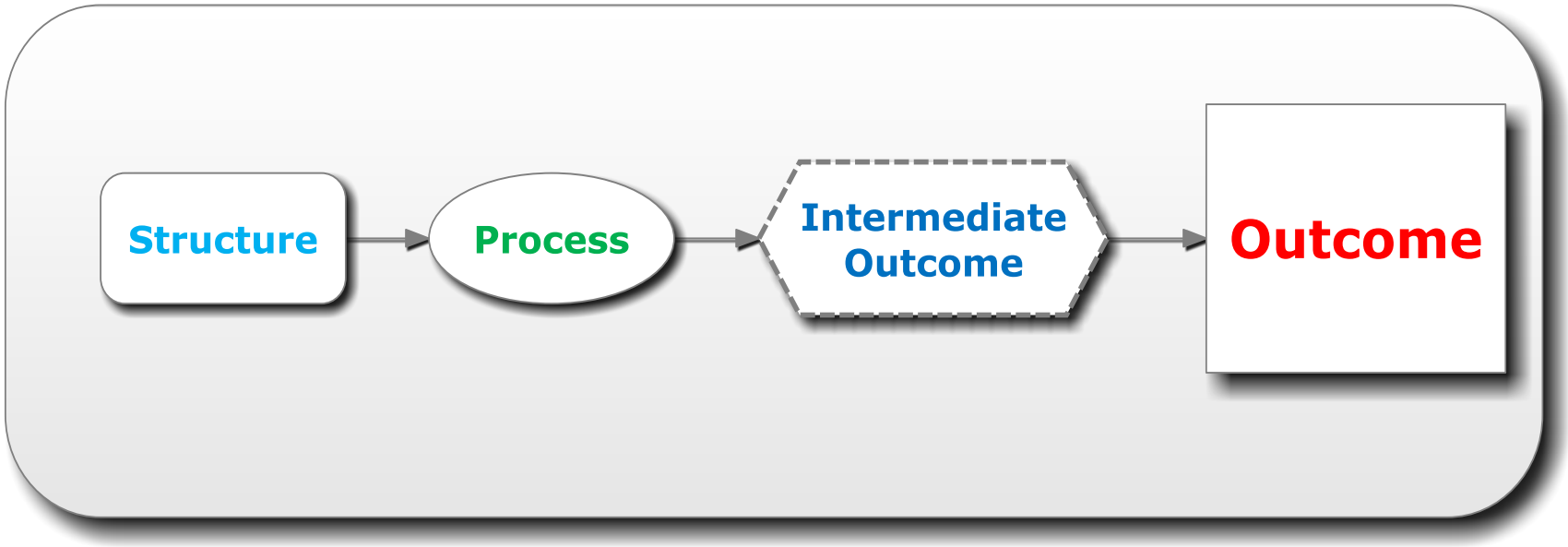
Task Force Guidance Reports

- New guidance for measure evaluation:
  - Evidence for the focus of measurement and Importance to Measure and Report
  - Measure Testing and Scientific Acceptability of Measure Properties
  - Measure Harmonization

Importance to Measure and Report

- The specific focus of what is measured should be considered **important enough to expend resources for measurement and reporting**, not only that it is related to an important broad topic area.
- These concepts are addressed in three sub-criteria:
  1) Addresses a **national goal/priority or high impact** aspect of healthcare
  2) Performance gap: **Opportunity for improvement**
  3) **Evidence to support the measure focus**
- **Measures must be judged to** meet all three subcriteria to pass this criterion and be evaluated against the remaining criteria.

Evidence for Measure Focus



- Hierarchical preference for
  - Outcomes linked to evidence-based processes/structures
  - Outcomes of substantial importance with plausible process/structure relationships
  - Intermediate outcomes
  - Processes/structures

Most closely linked to outcomes

Determining Strength of Evidence

Scientific Acceptability of Measure Properties

Reliability and Validity

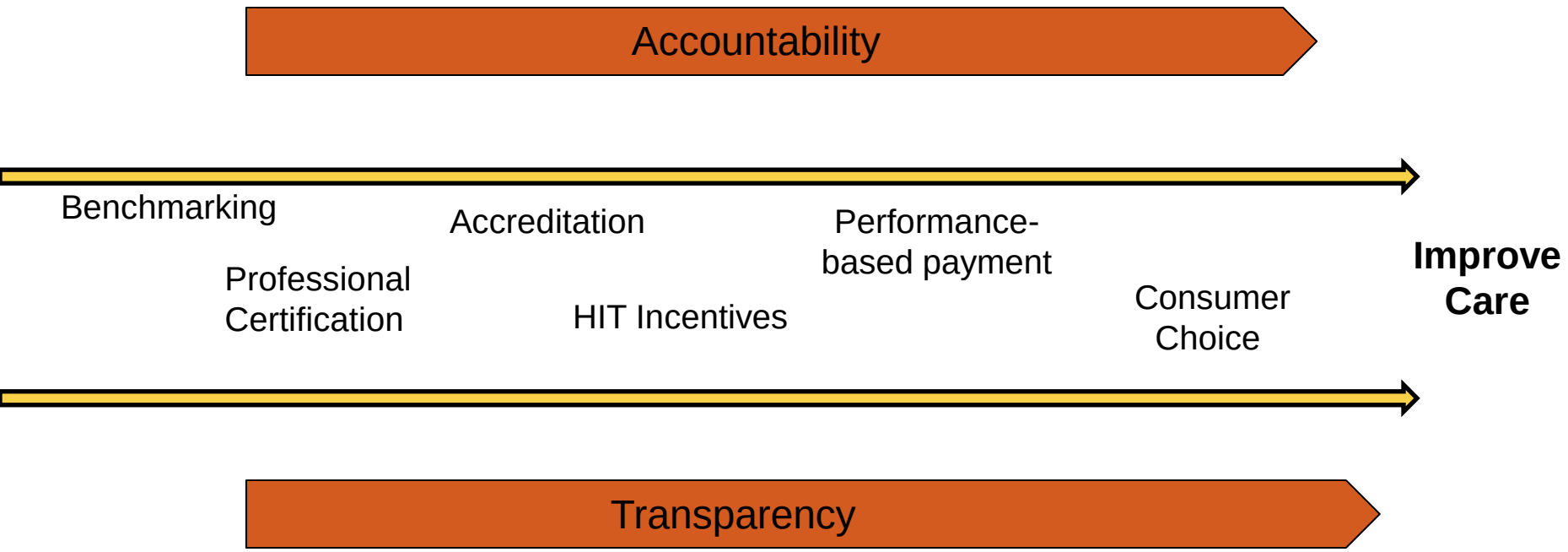
- Precise specifications
- Reliability and validity testing should be empirically demonstrated at the measure score and/or data element level*
- Exclusions supported by evidence
- Evidence-based risk adjustment strategy
- Identification of meaningful differences
- Identification of disparities

* *Limited exceptions: non-complex measures in gap areas required for time-sensitive legislative mandate*

Usability

- Requires demonstration that the measure results are meaningful and understandable to intended audiences and useful for both public reporting and informing quality improvement.
  - This is consistent with NQF policy of not endorsing measures solely for quality improvement.

Using Performance Information



Feasibility

- Extent to which the required data are readily available, **retrievable without undue burden**, and can be implemented for performance measurement.
  - Required data are routinely generated concurrent with and as a byproduct of care delivery.
  - Required data elements are available in electronic sources OR credible, near-term path to electronic collection
  - Data elements are specified for transition to EHRs

Comparison to Related or Competing Measures

If a measure meets the four criteria and there are endorsed/new related measures (same measure focus or same target population) or competing measures (both the same measure focus and same target population), the measures are compared to address harmonization and/or selection of the best measure.

- The measure specifications are harmonized with related measures **OR** the differences in specifications are justified.
- The measure is superior to competing measures (e.g., is a more valid or efficient way to measure) **OR** multiple measures are justified.

Endorsement Maintenance Process

- Review of endorsed measure occurs every 3 years
- Conduct full 9-step CDP project (including request for implementation comments)
- New and endorsed measures are reviewed against current measure evaluation criteria
- Review of new measures within the same topic area occurs at the same time with existing measures
  - —Drives toward parsimony in the volume of measures
  - —Supports harmonization of measure specifications

Expedited Review

- All of the following criteria should be met prior to consideration by the CSAC for an expedited review:
  - the extent to which the measures under consideration have 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 measures
- For expedited reviews, each CDP step will be no less than ten business days (instead of 30 calendar days)

Thank You

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Evaluation of Subcriterion 1c

Quantity of Body of Evidence	Quality of Body of Evidence	Consistency of Body of Evidence	Pass Subcriterion 1c
Mod-High	Mod-High	Mod-High	Yes
Low	Mod-High	Moderate (if only 1 study high consistency not possible)	Yes, but only if judgment that additional research is unlikely to change conclusion that benefits to patients outweighs harms; otherwise, No
Mod-High	Low	Mod-High	Yes, but only if judgment that potential benefits to patients clearly outweigh potential harms; otherwise, No
Low-Mod-High	Low-Mod-High	Low	No
Low	Low	Low	No

Evaluation of Subcriterion 1c

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	Pass Subcriterion 1c
Exception to Empirical Evidence For a health outcome measure: A rationale supports the relationship of the health outcome to processes of care or the importance of measuring the health outcome	Yes, if judgment that the rationale supports the relationship of the health outcome to processes of care or the importance of measuring the health outcome
Potential Exception to Empirical Evidence For a ***structure or process measure***: there is no empirical evidence, and expert opinion is systematically assessed with agreement that the benefits to patients greatly outweigh potential harms and there is a strong rationale for the importance of measuring performance	Yes, but only if judgment that potential benefits to patients clearly outweigh potential harms; otherwise, No

Scientific Acceptability Ratings

Validity	Reliability	Pass Scientific Acceptability Measure Properties
High	Moderate-High	Yes
	Low	No, inconsistent
Moderate	Moderate-High	Yes
	Low	No, inconsistent
Low	Any rating	No

NQF Measure Evaluation Criteria Handout

Tab 10

NATIONAL QUALITY FORUM

Measure Evaluation Criteria
January 2011

Conditions for Consideration
Several conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards. **If any of the conditions are not met, the measure will not be accepted for consideration.**

A. The measure is in the public domain or a measure steward agreement is signed.

B. The measure owner/steward verifies there is an identified responsible entity and a process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every three years.

C. The intended use of the measure includes both public reporting and quality improvement.

D. The measure is fully specified and tested for reliability and validity.[1]

E. The measure developer/steward attests that harmonization with related measures and issues with competing measures have been considered and addressed, as appropriate.

F. The requested measure submission information is complete and responsive to the questions so that all the information needed to evaluate all criteria is provided.

Note
1. A measure that has not been tested for reliability and validity is only potentially eligible for time-limited endorsement if all of the following conditions are met: 1) the measure topic is not addressed by an endorsed measure; 2) it is relevant to a critical timeline (e.g., legislative mandate) for implementing endorsed measures; 3) the measure is not complex (requiring risk adjustment or a composite); and 4) the measure steward verifies that testing will be completed within 12 months of endorsement.

Criteria for Evaluation
If all conditions for consideration are met, candidate measures are evaluated for their suitability based on four sets of standardized criteria in the following order: *Importance to Measure and Report*, *Scientific Acceptability of Measure Properties*, *Usability*, and *Feasibility*. Not all acceptable measures will be equally strong among each set of criteria. The assessment of each criterion is a matter of degree. However, if a measure is not judged to have met minimum requirements for *Importance to Measure and Report* or *Scientific Acceptability of Measure Properties*, it cannot be recommended for endorsement and will not be evaluated against the remaining criteria.

1. Impact, Opportunity, Evidence—Importance to Measure and Report: Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-impact aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to*** *meet all three subcriteria to pass this criterion and be evaluated against the remaining criteria.*

1a. High Impact
The measure focus addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF;

OR

- a demonstrated high-impact aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

AND

1b. Performance Gap
Demonstration of quality problems and opportunity for improvement, i.e., data[2] demonstrating considerable variation, or overall less-than-optimal performance, in the quality of care across providers and/or population groups (disparities in care).

AND

1c. Evidence to Support the Measure Focus
The measure focus is a health outcome or is evidence-based, demonstrated as follows:
- Health outcome:[3] a rationale supports the relationship of the health outcome to processes or structures of care.
- Intermediate clinical outcome, Process,[4] or Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence[5] that the measure focus leads to a desired health outcome.
- Patient experience with care: evidence that the measured aspects of care are those valued by patients and for which the patient is the best and/or only source of information OR that patient experience with care is correlated with desired outcomes.
- Efficiency:[6] evidence for the quality component as noted above.

Notes
2. Examples of data on opportunity for improvement include, but are not limited to: prior studies, epidemiologic data, or data from pilot testing or implementation of the proposed measure. If data are not available, the measure focus is systematically assessed (e.g., expert panel rating) and judged to be a quality problem.
3. Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.
4. Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement.
5. The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) grading definitions and methods, or Grading of Recommendations, Assessment, Development and Evaluation (GRADE) guidelines.
6. Measures of efficiency combine the concepts of resource use and quality (NQF's Measurement Framework: Evaluating Efficiency Across Episodes of Care; AQA Principles of Efficiency Measures).

2. Reliability and Validity—Scientific Acceptability of Measure Properties: Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.
Measures must be judged to *meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.*

2a. Reliability
2a1. The measure is well defined and precisely specified[7] so it can be implemented consistently within and across organizations and allow for comparability. EHR measure specifications are based on the quality data model (QDM).[8]

2a2. Reliability testing[9] demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise.

2b. Validity
2b1. The measure specifications[7] are consistent with the evidence presented to support the focus of measurement under criterion 1c. The measure is specified to capture the most inclusive target population indicated by the evidence, and exclusions are supported by the evidence.

2b2. Validity testing[10] demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality.

2b3. Exclusions are supported by the clinical evidence; otherwise, they are supported by evidence of sufficient frequency of occurrence so that results are distorted without the exclusion;[11]

AND

If patient preference (e.g., informed decisionmaking) is a basis for exclusion, there must be evidence that the exclusion impacts performance on the measure; in such cases, the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).[12]

2b4. For outcome measures and other measures when indicated (e.g., resource use):
- an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified; is based on factors that influence the measured outcome (but not factors related to disparities in care or the quality of care) and are present at start of care;[13,14] and has demonstrated adequate discrimination and calibration

OR

- rationale/data support no risk adjustment/ stratification.

2b5. Data analysis of computed measure scores demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful[15] differences in performance;

OR

there is evidence of overall less-than-optimal performance.

2b6. If multiple data sources/methods are specified, there is demonstration they produce comparable results.

2c. Disparities
If disparities in care have been identified, measure specifications, scoring, and analysis allow for identification of disparities through stratification of results (e.g., by race, ethnicity, socioeconomic status, gender);

OR

rationale/data justifies why stratification is not necessary or not feasible.

Notes
7. Measure specifications include the target population (denominator) to whom the measure applies, identification of

those from the target population who achieved the specific measure focus (numerator, target condition, event, outcome), measurement time window, exclusions, risk adjustment/stratification, definitions, data source, code lists with descriptors, sampling, scoring/computation.
8. EHR measure specifications include data type from the QDM, code lists, EHR field, measure logic, original source of the data, recorder, and setting.
9. Reliability testing applies to both the data elements and computed measure score. Examples of reliability testing for data elements include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing of the measure score addresses precision of measurement (e.g., signal-to-noise).
10. Validity testing applies to both the data elements and computed measure score. Validity testing of data elements typically analyzes agreement with another authoritative source of the same information. Examples of validity testing of the measure score include, but are not limited to: testing hypotheses that the measures scores indicate quality of care, e.g., measure scores are different for groups known to have differences in quality assessed by another valid quality measure or method; correlation of measure scores with another valid indicator of quality for the specific topic; or relationship to conceptually related measures (e.g., scores on process measures to scores on outcome measures). Face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process, by identified experts, and explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality.
11. Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, variability of exclusions across providers, and sensitivity analyses with and without the exclusion.
12. Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.
13. Risk factors that influence outcomes should not be specified as exclusions.
14. Risk models should not obscure disparities in care for populations by including factors that are associated with differences/inequalities in care, such as race, socioeconomic status, or gender (e.g., poorer treatment outcomes of African American men with prostate cancer or inequalities in treatment for CVD risk factors between men and women). It is preferable to stratify measures by race and socioeconomic status rather than to adjust out the differences.
15. With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74 percent v. 75 percent) is clinically meaningful; or whether a statistically significant difference of $25 in cost for an episode of care (e.g., $5,000 v. $5,025) is practically meaningful. Measures with overall less-than-optimal performance may not demonstrate much variability across providers.

3. Usability: Extent to which intended audiences (e.g., consumers, purchasers, providers, policymakers) can understand the results of the measure and find them useful for decisionmaking.

3a. Demonstration that information produced by the measure is meaningful, understandable, and useful to the intended audiences for public reporting (e.g., focus group, cognitive testing) or rationale;

AND

3b. Demonstration that information produced by the measure is meaningful, understandable, and useful to the intended audiences for informing quality improvement[16] (e.g., quality improvement initiatives) or rationale.

Note
16. An important outcome that may not have an identified improvement strategy still can be useful for informing quality improvement by identifying the need for and stimulating new approaches to improvement.

4. Feasibility: Extent to which the required data are readily available or could be captured without undue burden and can be implemented for performance measurement.

4a. For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

4b. The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

4c. Susceptibility to inaccuracies, errors, or unintended consequences and the ability to audit the data items to detect such problems are identified.

4d. Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality,[17] etc.) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use).

Note
17. All data collection must conform to laws regarding protected health information. Patient confidentiality is of particular concern with measures based on patient surveys and when there are small numbers of patients.

5. Comparison to Related or Competing Measures
If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5a. The measure specifications are harmonized[18] with related measures;

OR

the differences in specifications are justified.

5b. The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

multiple measures are justified.

Note
18. Measure harmonization refers to the standardization of specifications for related measures with the same measure focus (e.g., *influenza immunization* of patients in hospitals or nursing homes); related measures with the same target population (e.g., eye exam and HbA1c for *patients with diabetes*); or definitions applicable to many measures (e.g., age designation for children) so that they are uniform or compatible, unless differences are justified (e.g., dictated by the evidence). The dimensions of harmonization can include numerator, denominator, exclusions, calculation, and data source and collection instructions. The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources.

MAP Coordinating Committee In-Person Meeting Day 1 Recap

Tab 11

Measure Applications Partnership Coordinating Committee

In-Person Meeting #1

Recap of Day 1

Establishment of the MAP Decision Making Framework

- National Quality Strategy three aims and six priorities established as foundational
- HHS Multiple Chronic Conditions Framework added as an input
- Attention to equity across the NQS priorities
- Connecting to financing and delivery models as broader context (e.g. ACOs)

Consideration of MAP Measure Criteria

- Promote “systemness”
- Enable action by providers
- Help consumers make rational judgments
- Contribute to improved outcomes
- Assess burden of measurement
- Promote teams and shared accountability
- Address various levels of accountability in a cascading fashion

Consideration of MAP Measure Criteria continued…

- Contribute to a coherent measure set
- Tailor criteria for a purpose (e.g. process vs. outcomes, public reporting vs. payment, populations)
- Address public/private alignment upstream
- Use endorsement information as a baseline
- Contribute to parsimony (e.g. “twofers”)
- Assess quantifiable impact

MAP Workgroup Charges and Tasks

- Address HHS tasks while taking into account alignment with the private sector
- Setting appropriate expectations given the quick turnaround times (e.g. identifying work for subsequent phases)
- Cross linking between dual eligible beneficiaries task and PAC/LTC task
- Focusing on models of care rather than individual measures

MAP Workgroup Charges and Tasks continued…

- Considering cancer care beyond PPS-exempt hospitals
- Recognizing different measure considerations for PAC vs LTC (e.g. transitional vs. maintaining functionality and quality of life)
- Attending to quality from a family perspective for hospice facilities and programs