MEASURE APPLICATIONS PARTNERSHIP

CONVENED BY THE NATIONAL QUALITY FORUM

MEETING MATERIALS

for

COORDINATING COMMITTEE IN-PERSON MEETING

JUNE 21-22, 2011

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Agenda

Tab 1

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Coordinating Committee
In-Person Meeting #2

Embassy Suites DC Convention Center
900 10th St NW
Washington, DC

DAY 1 AGENDA: JUNE 21, 2011

Meeting objectives:

- *Establish coordination strategy elements*
- *Adopt a working set of measure selection criteria*
- *Review interim findings from Clinician, Ad Hoc Safety, and Dual Eligible Beneficiaries Workgroups and a synthesis of themes*
- *Provide guidance to workgroups on coordination strategies*

8:30 am **Breakfast**

9:00 am **Welcome, Introductions, and Review of Meeting Objectives**
George Isham and Beth McGlynn, Committee Co-Chairs

9:20 am **Emerging Elements for Coordination Strategies**
George Isham

- *Measures and measurement issues*
- *Data sources and HIT implications*
- *Alignment*
- *Special considerations for dual eligible beneficiaries*
- *Pathway for improving measure application*
- *Committee discussion and questions*

9:35 am **Data Sources and HIT Implications**
George Isham
Floyd Eisenberg, Senior Vice President, HIT, NQF

- *Committee discussion and questions*
- *Opportunity for public comment*

10:35 am **Measure Selection Criteria**
Beth McGlynn
Tom Valuck, Senior Vice President, Strategic Partnerships, NQF
Helen Burstin, Senior Vice President, Performance Measures, NQF
Arnold Milstein, Director, Stanford Clinical Excellence Research Center

- *Coordinating Committee role*
- *Clinician Workgroup input*

- *Stanford input*
- *Synthesis of inputs*
- *Committee discussion and questions*

11:45 am **Working Lunch**

12:15 pm **Measure Selection Criteria: Small Group Session, Discussion, and Next Steps**
Beth McGlynn

- *Small group session*
- *Reporting out from each small group*
- *Committee discussion and questions*
- *Adoption of working set of measure selection criteria*
- *Committee discussion and questions*
- *Opportunity for public comment*

3:00 pm **Clinician Performance Measurement Coordination Strategy across Federal Programs**
George Isham
Gene Nelson, Clinician Workgroup Member

- *Review of Clinician Workgroup interim findings*
- *Committee discussion and questions*
- *Opportunity for public comment*

4:15 pm **Summary of Day 1 and Look-Forward to Day 2**
George Isham and Beth McGlynn

4:45 pm **Adjourn for the Day**

NATIONAL QUALITY FORUM
MEASURE APPLICATIONS PARTNERSHIP

Coordinating Committee
In-Person Meeting #2

DAY 2 AGENDA: JUNE 22, 2011

8:30 am **Breakfast**

9:00 am **Welcome and Recap of Day 1**
George Isham and Beth McGlynn

9:30 am **Healthcare-Acquired Conditions and Readmissions Coordination Strategy across Public and Private Payers**
George Isham
Frank Opelka, Chair, Ad Hoc Safety Workgroup
- *Review of Ad Hoc Safety Workgroup interim findings*
- *Committee discussion and questions*
- *Opportunity for public comment*

10:45 am **Break**

11:00 am **Dual Eligible Beneficiaries Quality Measurement Strategy**
Beth McGlynn
Alice Lind, Chair, Dual Eligible Beneficiaries Workgroup
- *Review of Dual Eligible Beneficiaries Workgroup interim findings*
  - *Initial guiding principles*
  - *High leverage opportunities for quality improvement*
  - *Next steps*
- *Committee discussion and questions*
- *Opportunity for public comment*

12:30 pm **Working Lunch**

1:00 pm **Synthesis of Emerging Workgroup Themes and Committee Guidance to Workgroups**
George Isham and Beth McGlynn
- *Committee discussion and questions*
- *Opportunity for public comment*

2:45 pm **Summation and Path Forward**
George Isham and Beth McGlynn

3:00 pm **Adjourn**

Powerpoint Slides

Tab 2

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Measure Applications Partnership Coordinating Committee

In-Person Meeting #2

June 21-22, 2011
9:00 am – 5:00 pm EST

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Welcome, Introductions, and Review of Meeting Objectives

Meeting Objectives

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- Establish coordination strategy elements
- Adopt a working set of measure selection criteria
- Review interim findings from Clinician, Ad Hoc Safety, and Dual Eligible Beneficiaries Workgroups and a synthesis of themes
- Provide guidance to workgroups on coordination strategies

Meeting Agenda: Day 1

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- Welcome, Introductions, and Review of Meeting Objectives
- Emerging Elements for Coordination Strategies
- Data Sources and HIT Implications
- Measure Selection Criteria
- Clinician Performance Measurement Coordination Strategy across Federal Programs
- Summary of Day 1 and Look-Forward to Day 2
- Adjourn for the day

MAP Coordinating Committee Charge

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

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

MAP Decision-Making Framework

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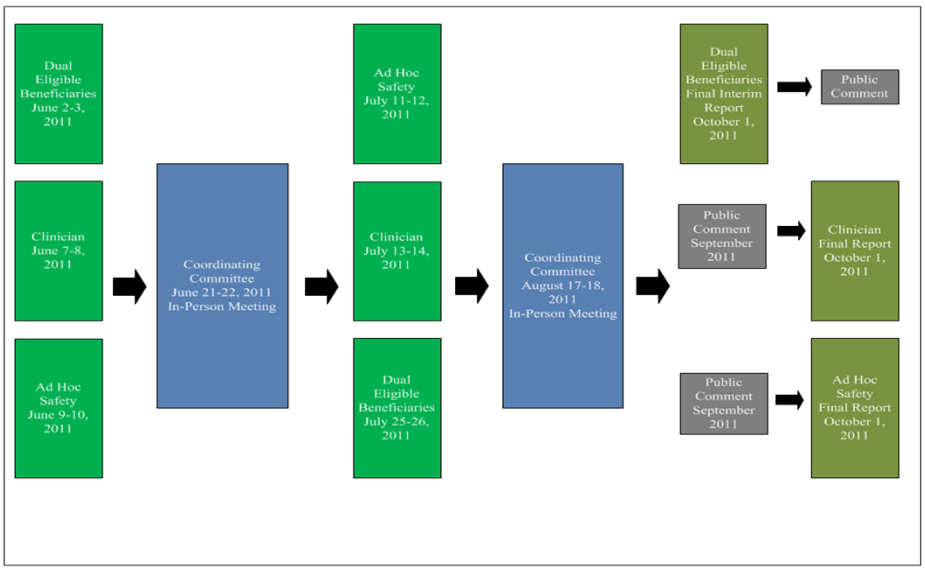
- Overarching principle:
  - The aims and priorities of the National Quality Strategy (NQS) will provide the foundation for MAP decision-making.
- Additional factors for consideration:
  - The two dimensional framework for performance measurement—NQS priorities and high impact conditions —will provide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

MAP Coordinating Committee Timeline and Processes – October 1, 2011 HHS Reports



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Emerging Elements for Coordination Strategies

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Emerging Elements for Coordination Strategies

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- Measures and measurement issues
- Data sources and HIT implications
- Alignment
- Special considerations for dual eligible beneficiaries
- Pathway for improving measure application

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Committee Discussion and Questions

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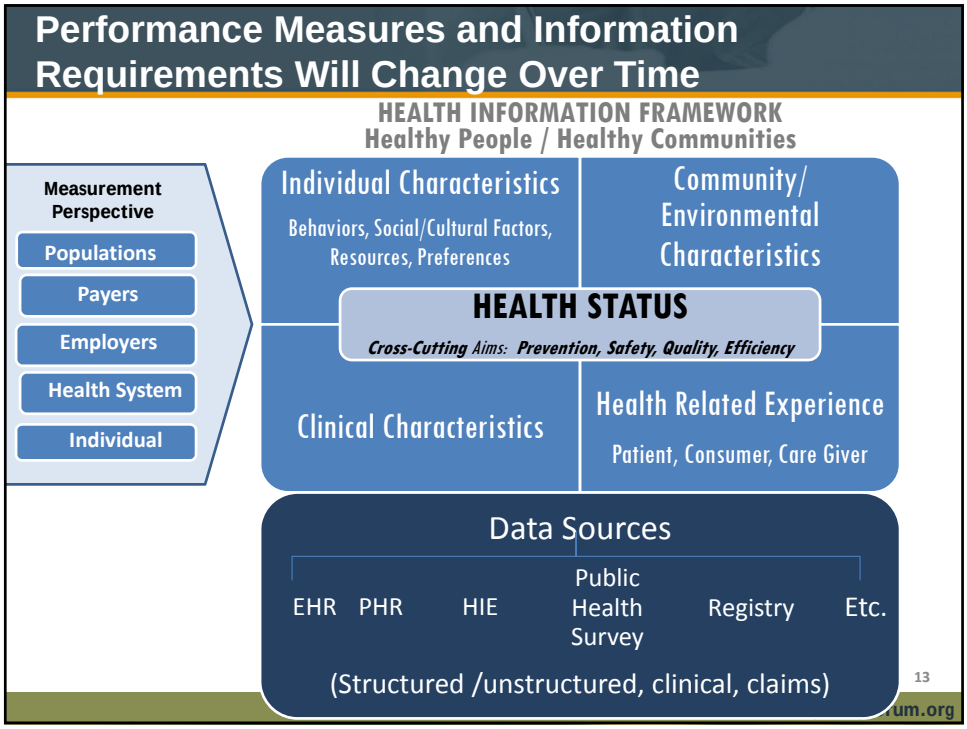
Data Sources and HIT Implications

Data, Measurement, and Health IT Are Inextricably Linked

- **Data Sources** → • Capture the right data
- **Performance Measures** → • Calculate the performance measure
- **EHRs and HIT tools** → • Provide real-time information to clinicians and other providers with decision support
- **E-Infra structure** → • Publicly report for secondary uses: accountability, payment, public health, and comparative effectiveness


Performance Measures and Information Requirements Will Change Over Time
HEALTH INFORMATION FRAMEWORK
Healthy People / Healthy Communities
Measurement Perspective
Populations
Payers
Employers
Health System
Individual
Individual Characteristics
Behaviors, Social/Cultural Factors, Resources, Preferences
Community/ Environmental Characteristics
HEALTH STATUS
Cross-Cutting Aims: Prevention, Safety, Quality, Efficiency
Clinical Characteristics
Health Related Experience
Patient, Consumer, Care Giver
Data Sources
EHR
PHR
HIE
Public Health Survey
Registry
Etc.
(Structured /unstructured, clinical, claims)
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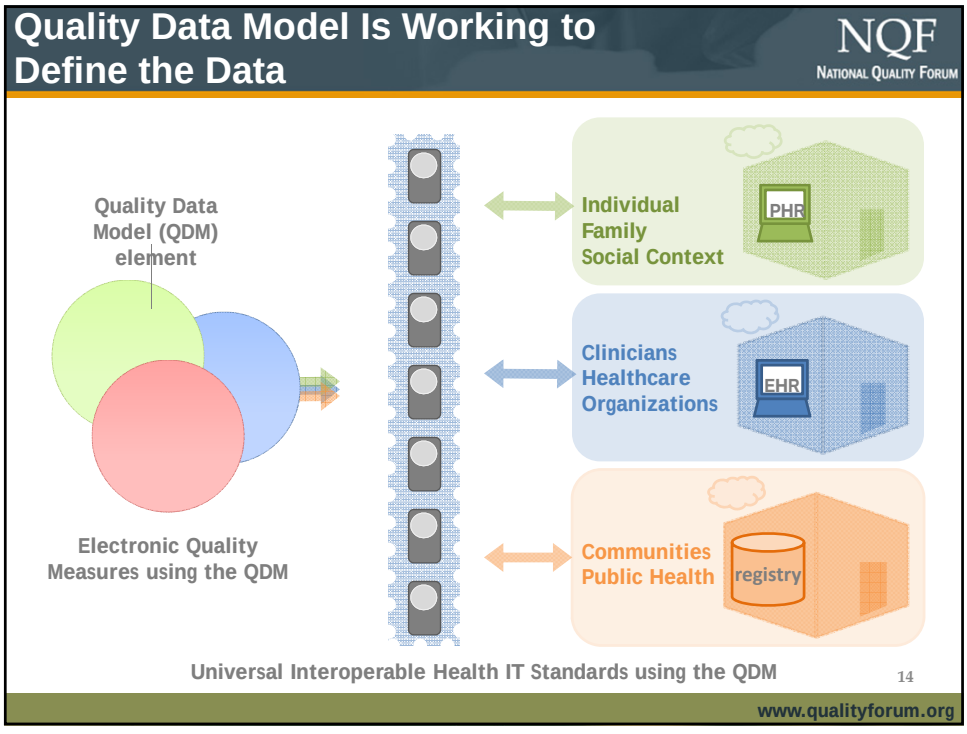
Quality Data Model Is Working to Define the Data
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Quality Data Model (QDM) element
Electronic Quality Measures using the QDM
Individual
Family
Social Context
PHR
Clinicians
Healthcare
Organizations
EHR
Communities
Public Health
registry
Universal Interoperable Health IT Standards using the QDM
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NQF is Helping Build the Necessary Electronic Infrastructure

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Capture Data → Calculate Performance Measures → Real-Time Info to Clinician → Publicly Report

What (data/information) is available in an EHR that I can use to create my measure?

Quality Data Model

How can I say what I want/need to say so that all readers will interpret it the same way?

Logic

Standards

How can I create my measure so that an EHR and the average clinician can each understand it?

Measure Authoring Tool

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Example: Medication Adherence (Current)

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Patient	Pharmacy	Payer	Clinician
Measures: • patient-reported outcomes • experience of care (CAHPS) • SDM	Measures: • medication adherence • medication reconciliation	Measures: • medication adherence • medication reconciliation • drug-disease interactions	Measures: • care coordination across providers • shared decision making • clinical outcomes
Data Sources: • PHRs • registry • clinical records • surveys	Data sources: • claims	Data sources: • claims • clinical	Data sources: • claims • clinical • registries

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Example: Medication Adherence (Future)

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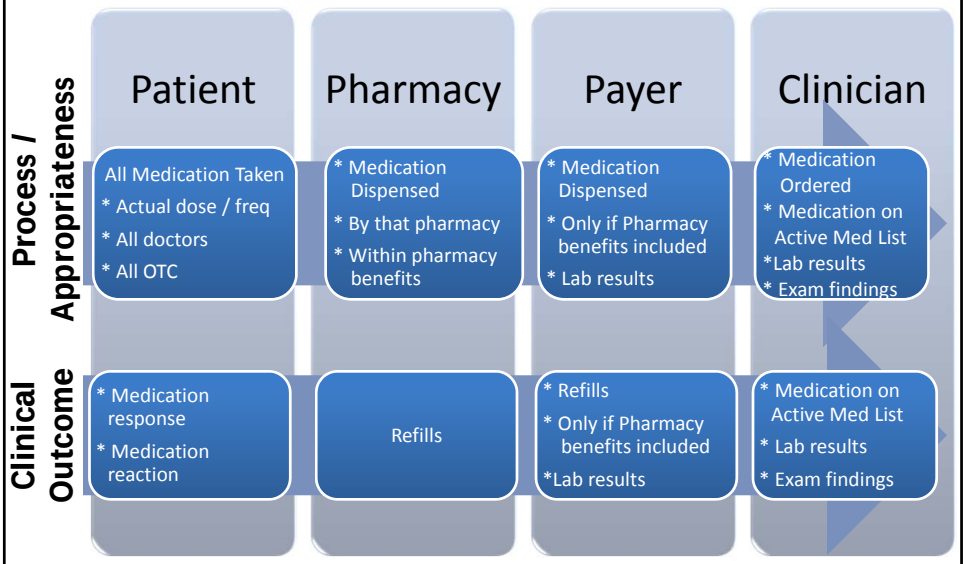

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Key Questions: eMeasures, Data Sources and Platforms, and Stakeholders

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Issue	Potential Policy Solutions	HIT Role

How can a coordinated strategy move the system toward electronic measures and interoperable data platforms?	• Certification and Meaningful Use Criteria using the same standards for primary data capture and interoperability as for secondary uses
	  • Templates
	  • Vocabulary
		• Parsimoniously harmonize overlapping standards
		• Fill gaps where standards are lacking

How should the data platform (e.g., EHR) be constructed to support various levels of analysis Clinician vs. health plan vs. health system vs. community	• Consensus for attribution at individual, group, and higher levels. • Criteria to differentiate patient outcomes vs. provider effectiveness (not always a direct relationship)	• Standards for rolling up individual providers to groups, and higher levels
How can approaches to data collection best be coordinated to the minimize burden on providers, stakeholders?	• Certification and Meaningful Use Criteria that require data driven approach to information	• Standard model in information (QDM)

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Key Issues: Public and Private Programs, Measure Reporting Requirements, Data

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Issue	Potential Policy Solutions	HIT Role
Separate reporting processes for the same measures under different public and private programs	• Harmonization of public and private programs • Alignment and use of same criteria and formats for requesting and reporting information for measurement	• Parsimoniously harmonize overlapping standards for measure specification and reporting
Submission of data vs. measure calculations with certified EHR technology	• Harmonization of public and private programs • Certification of EHR modular capabilities • Policy decision	• Standards to enable workflow for data submission or summary reporting (QRDA)
Lack of standardized set of data elements for EHRs	• Certification and Meaningful Use requirements for standard vocabularies and templates	• Standard value sets for incorporation within EHRs (QDM)
Clarification of best use of claims, registries, and EHRs	• Consensus for appropriate workflows as guidance to enable local implementation decisions • Standardization of information submission to registries identical to interoperability models	• Consistent, standard model for expressing information (QDM)

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Committee Discussion and Questions

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Opportunity for Public Comment

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Measure Selection Criteria

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Coordinating Committee Role

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Measures to Be Implemented Through the Federal Rulemaking Process

Task Description	Deliverable	Timeline
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 metrics for encouraging such improvement.	Final report containing Coordinating Committee framework for decision-making and proposed measures	Draft Report: January 2012 Final Report: February 1, 2012

Coordinating Committee with input from all workgroups

MAP Coordinating Committee Timeline and Processes – February 1, 2012 Pre-Rulemaking Analysis Report

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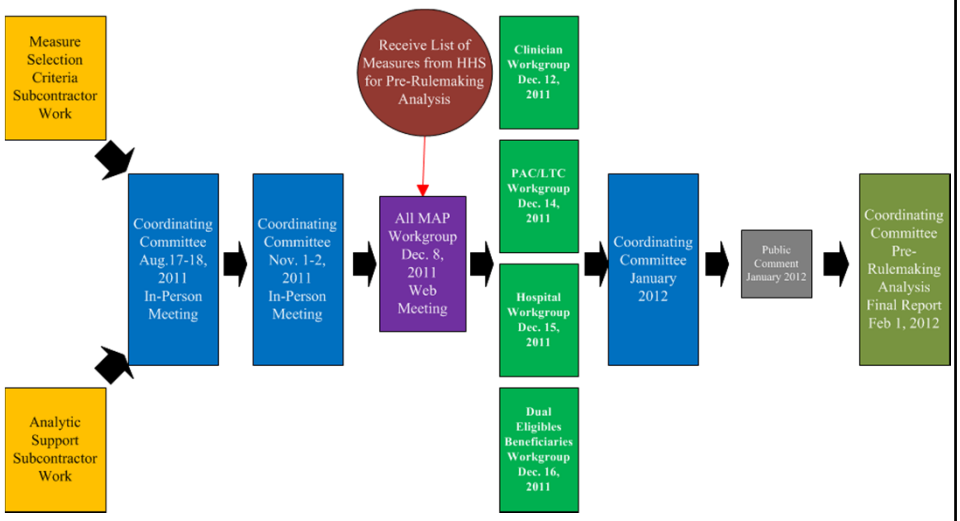

Quality Measurement Enterprise

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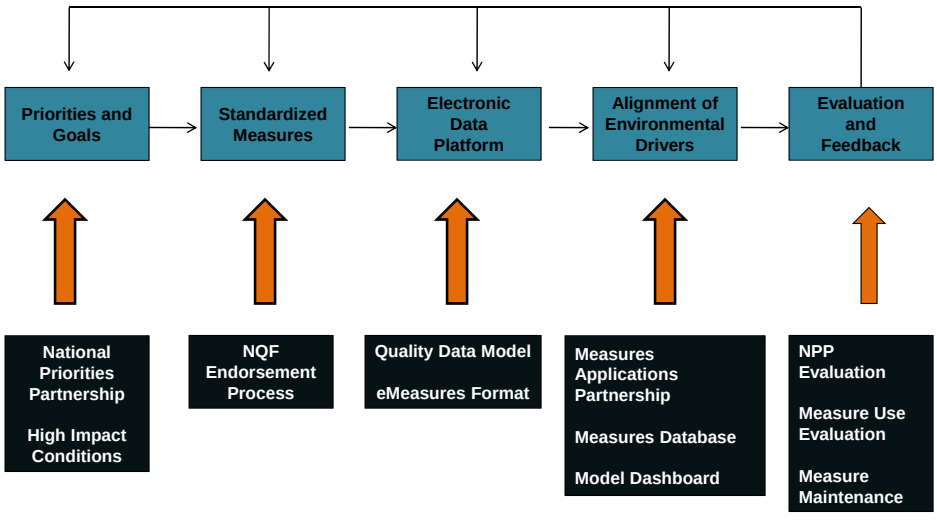


NQF Endorsement Process Evaluation Criteria

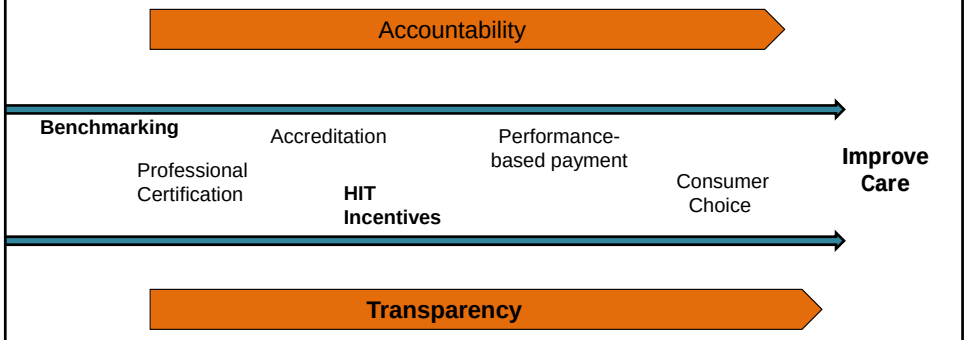
Helen Burstin, MD, MPH
Senior Vice President, Performance Measures
National Quality Forum

MAP Coordinating Committee
June 21-22, 2011

NQF Evaluation Criteria

- **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**

Using Performance Information



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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

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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

Helen Burstin, MD, MPH
hburstin@qualityforum.org

Measure Selection Principles from May 3-4 Coordinating Committee Meeting

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

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Clinician Workgroup Input

Clinician Workgroup Input- Priority Measure Selection Principles

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- Promote shared accountability and "teamness"
  - Actionable
  - Longitudinal
- Address multiple levels of analysis
  - Individual v. group
  - Cascading measures
- Useful to intended audiences
  - Shared decision making
  - Functional status
  - Quality of life/well-being
- Potential for unintended consequences
- Balance comprehensiveness and parsimony

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Stanford Input

Steps to Identify Candidate Measure Selection Criteria

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Step 1
- **Scan existing criteria for new application-relevant concepts**
- Research team scanned 35+ existing historical criteria sets to identify new concepts for application-specific measure selection criteria that are not addressed in the NQF endorsement criteria

Step 2
- **Perform use cases through population lens (ambulatory, inpatient, LTC, duals)**
- Research team identified measures selection requirements for each setting and suggested additional measure selection criteria needed to meet those requirements

Step 3
- **Perform use cases through application lens (payment, reporting, monitoring)**
- Key informants to identify additional measure selection criteria for each of the 3 target applications
- Reconcile conflicts by adopting a "primary user" for each application and prioritizing their requirements

Step 4
- **Synthesize and reconcile proposed measure selection criteria for selection to recommend to MAP**
- Research team synthesizes proposed measure selection criteria into a candidate set for applications

Selected Findings from Criteria Scan

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A scan of 35+ criteria sets contributed concepts for measure selection criteria:

Priority and Outcome Focused	➢ Measures should explicitly address aspects of financial impact, accessibility and affordability ➢ Measures address a process that has few intervening care processes before the improved outcome is realized
Program Specific	➢ Measures have been fully tested and validated in the care setting in which they are intended to measure
Unintended Consequences	➢ Measures are insulated from unintended consequences of implementing (e.g., detect exclusion of high risk patients)
Comprehensiveness	➢ Measure sets should address the spectrum of care for a condition or population

Use Case Findings

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- NQF endorsement criteria were used as a baseline
- The team proposed additional measure selection criteria to address requirements for measures to be used in payment, public reporting, or program evaluation
- More information on methods can be found in the Appendix and by request from NQF

Population-based Use Cases

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Setting / Population	Use Case	Associated Measure Set
Ambulatory	Chronically Ill Patients	ACO Proposed Quality Measures
	Patients in Ambulatory Setting with EHR	Meaningful Use Clinical Quality Measures
	Primary Care Patients – Patient-Centered Medical Home	• PCMH Patient Experience Survey • Beacon PRO Pilot Measures • Patient Centered Primary Care Collaborative Center (PCPCC) Recommended Measures
Hospital	Value-based purchasing in hospitals	Inpatient Quality Reporting measures, HCAHPS
	Public reporting on cardiac surgery	Society of Thoracic Surgeons Adult Cardiac Surgery Measures
	Public reporting on non-Medicare	The Joint Commission Core Measures – Children's Asthma Care, Perinatal Care, etc.
Long Term Care	Monitoring and comparing nursing home quality	Minimum Data Set 3.0 Post Acute measures for nursing homes
		CASPER nurse staffing and nursing home inspections
Dual-Eligibles	Vulnerable elders	Assessing Care of Vulnerable Elders (ACOVE) -3
	Special needs populations	Special Needs Plan – structure and process measures

Use Cases: Cross-cutting Measure Selection Criteria

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- The following selected findings were relevant across all populations
- Where recommended selection criteria fit across multiple criteria domains, the team assigned them to one
- Recommended selection criteria are oriented toward selection of "sets" of measures vs. individual measures

Cost, Quality Alignment

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Example:

Process measures are often focused on correcting for underuse of screenings and preventive care.

Add cost of care and appropriate care measures to address overuse or misuse.

Potential measure selection criterion: *Measure sets should foster alignment between cost of care and quality performance.*

Explanation: There is potential for cost of care and quality conflicts. To ensure that accountability programs improve health care value, measure sets should balance incentives to reduce overuse in certain areas while encouraging better care and support in other areas.

Weight Measures by User Needs

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Example:

A patient in a LTC setting may assign a high weight to quality of life and functional status measures.

A dual eligibles program manager may assign a high weight to systemness measures.

A payer for ambulatory care may assign a high weight for overuse and episode of care measures.

Potential measure selection criterion:
Assign measure weights based on the users' needs.

Explanation:
An accountability program's measures need to be aligned with the interests of the intended users. The users' voice should be clearly heard in the debates to balance feasibility and other needs against the users' interests in better, more affordable health.

Methods for Alternative Measure Sets

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Example:

Providers with limited IT capability often unable to report lab results.

Diabetes care composite "A" has control measures and composite "B" limited to screening measures.

Potential measure selection criterion:
Lower burden measurement options should be incorporated into the measure set to enable provider participation if the provider is unable to supply data for all measures.

Explanation: Performance accountability programs should include a critical mass of providers for meaningful payment and public reporting uses. But, a number of providers could be excluded given uneven information capabilities/resources.

Performance Discrimination

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Example:

The performance thresholds is set to recognize 'top results' at 75th percentile; improvement is recognized as moving from lowest quartile to 50th percentile or higher.

Potential measure selection criterion: *Require that measures be accompanied by a use case -specific method of classifying performance.*

Explanation: Measure set utility for payment & reporting will depend upon performance classification to define meaningful differences among accountable entities. And, a performance classification approach can avert unintended consequences (e.g., recognize improvement and absolute performance).

Measure Aggregation

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Example:

Proposed ACO measures roll-up to 1 of 5 domains and then aggregated to a total quality score.

And 'at-risk' domain organized into 5 condition specific sub-domains.

Potential measure selection criterion: *Measure aggregation methods should accompany proposed measure sets to ensure performance information can be summarized at a level that is meaningful and useful for the intended audiences.*

Explanation: Sets of measures increase the complexity for the intended users.

Specify Applications

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Example:

Payment reduction versus enhancement

Minimum Data Set (MDS) for consumer choice of LTC facility.

Medicare Stars program for consumer choice of health plan.

State hospital reporting for consumer choice of treatment program.

Potential measure selection criterion:
Reporting and payment uses should be explicit to evaluate the proposed measures and methods in the context of the use.

Explanation:
Need to be explicit about the nature of the application. For example:

•Payment programs –distinguish if it is a payment reduction or a payment enhancement mechanism.

•Reporting programs –distinguish if reporting for: i) consumer choice of provider, ii) consumer engagement in treatment decisions, iii) marketplace recognition, iv) physician referral decision support etc.

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Promoting Standardized Measurement

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Example:

The Meaningful Use program requires providers to report certain measures but other measures are drawn from a larger library. As such, there is no standard measures set.

Potential measure selection criterion:
Proposed condition-specific or other sub-domain composites should include standard sets of measures.

Accompanying methods should offer flexibility – do not require that all providers report all measures.

Explanation: Across accountability programs, the proliferation of similar but distinct measure sets/composites will heighten provider burden & patient confusion. Flexibility can be created through alternative composites (e.g., advanced vs. basic).

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Anticipate Unintended Consequences

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Example:

Post-acute pain reduction measure could spur overprescribing. Include measures in the acute care composite that are a safeguard against such consequences.

Potential measure selection criterion:
Scrutinize measure sets to ensure that measures that are vulnerable to unintended consequences are offset by measures to detect/mitigate such consequences.

Explanation:
Payment and public reporting applications could prompt behaviors that are counter to best care or that exclude high-risk patients.

Multiple Dimensions in Domain

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Example:

Medicare Stars multi-item preventive care composite.

PCMH patient experience captured through multiple domains including coordination, shared decision-making and self care support.

Potential measure selection criterion:
Use groups of measures that address the same construct, condition, procedure, or setting.

Explanation: Given payment & reporting consequences, sets of measures are needed to capture multiple dimensions of the accountability program's quality and cost domains.

National Quality Strategy Aligned

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Example:

- Safe
- Engaged patient
- Coordinated care
- Effective treatment
- Healthy living
- Affordable

Potential measure selection criterion: *Use the 6 NQS domains to define a comprehensive accountability program. As measurement capability evolves, tighten criteria to address all 6 domains.*

Explanation: Accountability programs use a variety of performance dashboards – need a standard gauge of 'comprehensive accountability' to assess these programs and to spur alignment across public and private sector programs.

Setting-Specific Findings

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- Use case findings highlight measure selection criteria issues that are important to the setting/population
  - Ambulatory
  - Inpatient
  - Long-term / Post Acute Care
  - Dual Eligible Beneficiaries

Ambulatory Measure Selection Criteria Considerations

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1) Measure aggregation methods are needed for information to be usable by clinicians, patients, & others.

2) Flexibility to ensure a critical mass of providers participate in accountability programs. Address clinician's IT capacity through alternative measure sets, missing value methods etc.

3) Consider different objectives of shared accountability and consumer use. Systemness measures address important quality gaps but consumers most value relationship with doctor and other health professionals –"systems" are less relevant.

Inpatient Measure Selection Criteria Considerations

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1) More measures (relative to other use cases) are now "topped out," leaving measure sets that lack comprehensiveness.

2) Analytic methods (risk-adjusted outcomes) have been designed to compare a hospital with a national or regional benchmark, but public reporting applications entail ranking or comparisons among competing hospitals.

3) Brevity of inpatient stays can lead to accountability uncertainty & unintended consequences. Hospital care episodes should include pre-admit/post-discharge care to address cross-setting accountability.

LTC/PAC Measure Selection Criteria Considerations

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1) Transitions (from inpatient care, to home care) are not well addressed in existing measure sets and raise concerns about accountability and unintended consequences.

2) Measure selection criteria should recognize that decisions often are made by family members and other patient advocates; not by patients themselves.

3) Patients' individual values determine the goals of care, and raise the importance of specific outcomes and processes to achieve those outcomes (e.g., aggressive pain relief may aggravate delirium).

Duals Measure Selection Criteria Considerations

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1) Recognize, as part of deciding whether care delivery is efficient, that the care must first be appropriate, taking into account patient preferences and prognosis.

2) Recognize that patient experience and preferences may be difficult to obtain in patients with cognitive impairment. This could be addressed by use of surrogates.

3) Recognize that measures of care quality across sites have specific importance to dually eligible patients.

Resolve Measure Selection Criteria Conflicts

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Address overarching conflicts as foundation for measure selection criteria adoption

Innovation vs. continuity	Introducing new, compelling measures vs. retaining continuity of historical measures
Shared vs. individual accountability	Systemness concerns care system or cross-setting performance but consumers value physician-specific information. Components of measure sets will need to be shaped to different users
Understandability, comprehensiveness & science trade-offs	Measure sets contain multiple components that are critical to better health. Need composites for understandability. Composites may not meet psychometric rigor as some important dimensions of care/health not strongly related
Burden: practices' uneven IT capabilities	Set selection criteria to avoid LCD measures: reward advanced measure sets but allow 'starter sets.' Tradeoff re more complex accountability programs for IT/system variation

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Resolve Conflicts: Preventive Care as Illustration

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Preventive care measure sets example: an exercise in measure selection criteria setting to resolve or mitigate conflicts

Innovation vs. continuity	Measures innovation: health status change over time Measures continuity: cancer screening measures set – certain measures topping out/ceiling effect
Shared vs. individual accountability	System level: quit tobacco intervention Doctor level: doctor counsels patient diet/exercise
Understandability, comprehensiveness & science trade-offs	Preventive care composite can be roll-up of discrete quality dimensions: a) avoidable illness, b) screening, c) health status, d) patient counseling
Burden: practices' uneven IT capabilities	Reward advanced measure sets: patient-report health behaviors: nutrition, activity, exercise, alcohol & tobacco Allow 'starter sets': cancer screening measures

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Next Steps

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- Project team will incorporate findings from key informants regarding application – specific use cases
- A final set of candidate measure selection criteria will be recommended to the MAP, including suggestions for resolving selection criteria conflicts

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Synthesis of Inputs

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Committee Discussion and Questions

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Measure Selection Criteria: Small Group Session, Discussion, and Next Steps

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Small Group Session

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Reporting Out from Each Small Group

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Committee Discussion and Questions

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Adoption of a Working Set of Measure Selection Criteria

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Opportunity for Public Comment

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Clinician Performance Measurement Coordination Strategy across Federal Programs

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Measures for Use in the Improvement of Clinician Performance

Task Description	Deliverable	Timeline
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

Clinician Workgroup will advise the Coordinating Committee

Current Clinician Performance Measurement Programs

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Federal programs included in coordination strategy	Programs for additional consideration
Physician Quality Reporting System (PQRS)	Medicare Advantage/5-star rating
E-Prescribing Incentive Program	CHIPRA Initial Core Set Measures
Electronic Health Records (EHR)-Meaningful Use	Medicaid Core Measure Set
Physician Feedback/Value Modifier – [Previously called The Physician Resource Use Measurement and Reporting (RUR) Program]	ACO Proposed Regulations
Physician Compare	IHA (Integrated Healthcare Association – California Pay for performance Program)
	Blue Cross Blue Shield of Massachusetts Alternative Quality Contract

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Review of Clinician Workgroup Interim Findings

Elements of a Coordination Strategy

- Measures and measurement issues
  - Measure selection principles
  - Identification of measure gaps
  - Measure methodological issues
- Data source and HIT implications
- Special considerations for dual eligible beneficiaries
- Alignment with other settings
- Pathway for improving measure application

Measure and Measurement Issues

- Priority measure selection principles
- Early identification of measure gaps
  - Patient reported measures, including health risk and functional status for individuals and populations
  - Mental illness
  - Physical and mental disabilities*
  - Multiple chronic conditions*
  - Cross-setting and community support*
  - Cultural competence, language, health literacy*

  Starred (*) gaps were noted as areas that differentially impact the dual eligible population
- Measure methodological issues

Priority Measure Selection Principles

- Promote shared accountability and “teamness”
  - Actionable
  - Longitudinal
- Address multiple levels of analysis
  - Individual v. group
  - Cascading measures
- Useful to intended audiences
  - Shared decision making
  - Functional status
  - Quality of life/well-being
- Potential for unintended consequences
- Balance comprehensiveness and parsimony

Data Source and HIT Implications

- Types of data
  - Appropriateness of data source for specific measures, settings
  - Moving beyond clinical data, incorporating patient self-reported and non-clinical data
- Data collection during the course of care
- Promoting HIT adoption
- Timeliness and transparency of data

Elements of a Coordination Strategy

- Alignment with other settings
  - Alignment with other public/private initiatives including new payment and delivery models
  - Federal programmatic alignment issues–data collection and reporting, feedback, and public reporting
- Pathway for improving measure application
  - Few measures address all of the priority measure selection principles
  - Recognition of the limitations of current data systems and potential for measures to promote data integration
  - Consider how to move from current to ideal state for each element of coordination strategy

Coordinating Committee Guidance to the Clinician Workgroup

What opportunities for alignment with other initiatives should the Clinician Workgroup consider?

What challenges should the Clinician Workgroup address in setting a path for moving from the current to the ideal state?

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Summary of Day 1 and Look-Forward to Day 2

Meeting Agenda: Day 2

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- Welcome and Recap of Day 1
- Healthcare-Acquired Conditions and Readmissions Coordination Strategy across Public and Private Payers
- Dual Eligible Beneficiaries Quality Measurement Strategy
- Synthesis of Workgroup Interim Findings and Committee Guidance to Workgroups
- Summation and Path Forward

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Welcome and Recap of Day 1

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Healthcare – Acquired Conditions and Readmissions Coordination Strategy across Public and Private Payers

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Review of Ad Hoc Safety Workgroup Interim Findings

Measurement Strategy for Readmissions and Healthcare-Acquired Conditions (HACs) Across Public and Private Payers

Task Description	Deliverable	Timeline
Provide input to HHS on a coordination strategy for readmission and healthcare-acquired conditions (HACs) measurement across public and private payers.	Final report containing Coordinating Committee input regarding the optimal approach for coordinating readmission and HAC measurement across payers	Draft Report: September 2011 Final Report: October 1, 2011

Ad Hoc Safety Workgroup will advise the Coordinating Committee

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Partnership for Patients

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

Establishes 2 goals to achieve by the end of 2013:

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

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HACs and Readmissions

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

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

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

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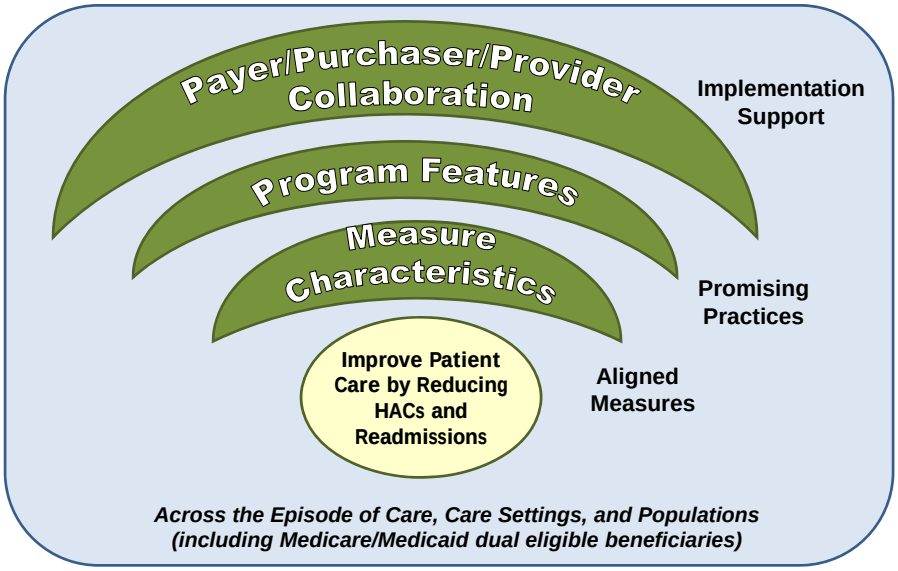
Dimensions of Public-Private Payer Alignment

Dimensions of Payer Alignment



Key Elements of a Coordination Strategy

HACs and Readmissions: Unique Considerations

There were many commonalities identified for an overall payer coordination strategy to reduce HACs and readmissions, though a few unique elements were noted:

HAC discussions focused on
- Data sources
- Processes

Readmissions discussions focused on
- Medical homes
- Patient-centeredness
- Communication systems
- Community

HACs and Readmissions: Collaboration

- Ensure that collaboration extends beyond payers and providers to include purchasers, communities, and patients/families/caregivers
  - Support improvement on the frontlines
  - Establish organizational cultures that encourage reporting safety issues
  - Reinforce teamwork and shared accountability
  - Engage patients in reduction of events (e.g., education using plain language, pharmacist education to prevent adverse drug events)
- Create joint accountability between hospitals, other providers, and community entities
  - Open communication lines between healthcare facilities and community supports
  - Consider impact of patient's home environment and social determinants on health

HACs and Readmissions: Collaboration

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- Share data and information across providers and settings
  - Provide real-time data to improve the care process (e.g., track admissions to different facilities, detect HAC post-discharge, notify whether prescriptions are filled, avoid drug-drug interactions and drug allergies)
  - Identify high risk patients through predictive modeling and share information with providers
  - Utilize the resources and toolkits of payers to advance improvement on the frontlines
  - Create a learning community to share promising practices
  - Provide data to purchasers and consumers to inform decision making

HACs and Readmissions: Program Features

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- Create incentive structures that support better care
  - Alignment of efforts across continuum to send consistent signals
  - Comprehensive care transition business model costs more than the cost of the readmissions penalty
- Bridge transition from hospital to community
  - Discharge planning and follow up both essential
  - Patient education to facilitate self-management
  - Medication reconciliation
  - Communication/collaboration between provider and community entities
  - Home visits
- Transparency is essential to drive improvement

HACs and Readmissions: Measure Characteristics

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- Measure alignment across public programs and public/private payers is essential
  - Consider statutory requirements for public programs (CMS, AHRQ, CDC, states)
  - Public/private payer measure alignment complicated by different populations
- Anticipate and monitor for consequences
  - Beyond unintended consequences, such as cost shifting/cherry picking
  - Length of stay and observation status as balancing measures
  - Optimum rate of readmissions may not be zero
- Attention to disparities
  - Risk adjustment vs. stratification
  - Improvement, as well as achievement; delta measures
- Measures should promote shared accountability (e.g., hospitals, other providers, community entities)

HACs and Readmissions: Measure Characteristics

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- Measures must be meaningful to all stakeholders and actionable
- Move beyond measures of occurrence to promoting preventive activities (e.g., ventilator bundle, central line insertion checklist)
- Consider pros and cons of different approaches to readmission measurement
  - 30 vs. 90 days
  - All payer vs. segmented
  - All cause readmissions vs. exclusions
  - All condition admissions vs. specific conditions
- Account for burden of data collection on providers
  - Volume, reliability, validity
- Measures would ideally be suitable for multiple purposes
  - Driving improvement vs. public reporting vs. payment

Guidance Requested by the Safety Workgroup

- Are there additional considerations related to the 3 dimensions (payer collaboration with purchasers and providers, promising program features, and measure characteristics) identified for payer alignment?
- Are there other opportunities for alignment beyond those identified by the Safety Workgroup?
- As the Safety Workgroup further develops a payer coordination strategy for implementation, are there specific practical considerations the Workgroup should take into account?

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Dual Eligible Beneficiaries Quality Measurement Strategy

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Measures that Address the Quality Issues Identified for Dual Eligible Beneficiaries

Task Description	Deliverable	Timeline
Provide input to HHS on identification of measures that address the quality issues for care provided to Medicare-Medicaid dual eligible beneficiaries.	Interim report containing framework for performance measurement for dual eligible beneficiaries	Draft Interim Report: September 2011 Final Interim Report: October 1, 2011
	Final report containing potential new performance measures to fill gaps in measurement for dual eligible beneficiaries	Draft Report: May 2012 Final Report: June 1, 2012

Dual Eligible Beneficiaries Workgroup will advise the Coordinating Committee

MAP Dual Eligible Beneficiaries Workgroup Charge

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The charge of the MAP Dual Eligible Beneficiaries Workgroup is to advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The Workgroup will:

- Develop a strategy for performance measurement for this unique population and identify the quality improvement opportunities with the largest potential impact.
- Identify a core set of current measures that address the identified quality issues and are applicable to both specific (e.g., Special Needs Plans, PACE) and broader care models (e.g., traditional FFS, ACOs, medical homes).
- Identify gaps in available measures for the dual eligible population, and propose modifications and/or new measure concepts to fill those gaps.
- Advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings.

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Review of Dual Eligible Beneficiaries Workgroup Interim Findings: Initial Guiding Principles

Guiding Principles

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Workgroup's Initial Vision for High Quality Care:
Individuals should have reliable access to a person-centered, culturally competent support system that helps them reach their personal goals through access to a range of healthcare services and community resources

- The population is defined by its heterogeneity and diversity; the group is best segmented by functional status or position on a trajectory spanning from health/wellness to disability/illness
- Culturally competent care must incorporate many dimensions, including race/ethnicity, language, level of health literacy, accessibility of the environment for people with disability, etc.
- Strategy for performance measurement should emphasize:
  - data exchange through portable, interoperable electronic health records
  - gathering and sharing information with the beneficiary
  - providing feedback to providers in order to facilitate continuous improvement
  - risk adjustment strategy to mitigate potential unintended consequences (e.g., adverse selection, overuse)
- Research needs and information gaps related to quality of care (e.g., high cost/high need patients, patient-reported outcomes)

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High-Leverage Opportunities for Quality Improvement

High-Leverage Improvement Opportunities

- Care coordination
  - Should take place across and within settings where care and community support is provided, across provider types, and across Medicare and Medicaid benefit structures
  - Include process measures, such as presence of a person-centered plan of care and medication reconciliation
  - Include measures of access to multi-disciplinary care team
  - Include measures related to advance planning and/or palliative care
- Quality of life
  - Care and supports are provided to enhance quality of life and enable individual to reach his/her self-determined goals
  - Include measures of functional status, to be evaluated over time
  - Include measures of an individual's ability to participate in his/her community
- Screening and assessment
  - Screening should be thorough and tailored to address the many complexities of the dual eligible beneficiary population to enable effective care
  - Assess home environment and availability of family and community supports
  - Screen for underlying mental and cognitive conditions, drug and alcohol history, HIV status, risk of falling, etc.

Coordinating Committee Guidance to the Dual Eligible Beneficiaries Workgroup

- Should the Workgroup consider additional guiding principles for its strategic approach to performance measurement?
- Are there additional high-leverage opportunities for performance improvement which should be considered by the Workgroup for prioritization?

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Synthesis of Emerging Workgroup Themes and Committee Guidance to Workgroups

MAP Workgroup Initial Findings: Cross-Cutting Themes

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		Clinician	Ad Hoc	Duals	NPP
Key considerations for measurement strategy	Communication/coordination across settings & into community	✓	✓	✓	BC
	Shared decisionmaking	✓		✓	BC
	Functional status	✓		✓	BC & HP
	Patient reported outcomes	✓		✓	BC & HP
	Quality of life/well-being	✓		✓	BC & HP
	Health literacy (care instructions understandable)		✓	✓	BC & HP
	Access to community/caregiver supports		✓	✓	BC & HP
	Medication adherence/reconciliation		✓	✓	BC
	Access to quality care		✓		BC & HP
	Care plan developed & followed			✓	BC
	Depression/mental health screening			✓	HP
	Culturally sensitive care			✓	BC & HP
	Patient experience			✓	BC
Key programmatic considerations	Transparency	✓	✓	✓	BC & HP
	Level of analysis	✓	✓	✓	
	Considering shared accountability/team-ness	✓	✓	✓	BC
	Considering unintended consequences	✓	✓		BC & HP
	Using HIT tools	✓		✓	BC
	Using disparities lens		✓	✓	BC & HP
	Based on multiple chronic conditions framework when necessary			✓	BC

Key Considerations for Measurement Strategy

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Area emphasized by all groups:

- Communication/coordination across settings and into the community

Areas emphasized by only one group:

- Care plans, culturally sensitive care, patient experience, and mental health screening – Dual Eligible Beneficiaries Workgroup
- Access to quality care – Safety Workgroup

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Key Programmatic Considerations

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Areas emphasized by all groups:

- Transparency, level of analysis, and shared accountability/"teamness"

Area emphasized by only one group:

- Use of a multiple chronic conditions measurement framework - Dual Eligible Beneficiaries Workgroup

Discussion Questions

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1. What is your reaction to the emerging themes?
2. Are there missing themes that should be added to the list?
3. What themes deserve more or less emphasis?

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Summation and Path Forward for the MAP

Committee Scope of Work & Timeline

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August 5, 2011

- Conduct a web meeting to review the workgroups' final findings in advance of the August in-person meeting.

August 17-18, 2011

- Convene an in-person meeting to review and approve the Clinician, Ad Hoc Safety, and Dual Eligible Beneficiaries Workgroups findings and recommendations.

November 1-2, 2011

- Conduct an in-person meeting to review and finalize findings and recommendations from the Post-Acute Care/Long-Term Care Workgroup on a coordination strategy for quality reporting across post-acute care and long-term care settings; prepare for December 2011 pre-rulemaking analysis.

Meeting Schedule

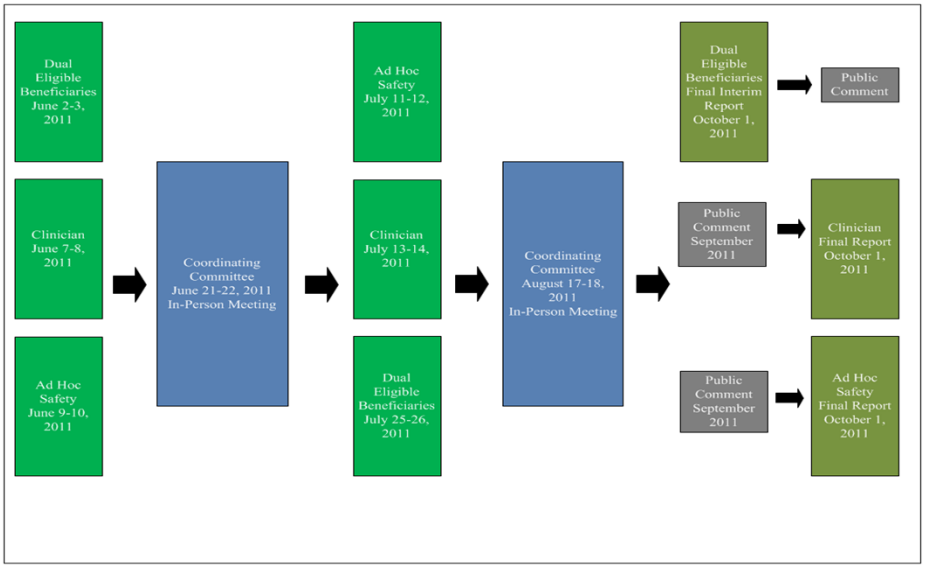
Coordinating Committee Web Meeting #2:
August 5, 2011 11:00 am-1:00 pm EST

Coordinating Committee In-Person #3:
August 17-18, 2011 (Washington, DC)

Public Webinar #1:
October 19, 2011 2:00-4:00 pm EST

Coordinating Committee In-Person Meeting #4:
November 1-2, 2011 (Washington, DC)

MAP Coordinating Committee Timeline and Processes – October 1, 2011 HHS Reports



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Appendix

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Review of Member Terms

Committee Member Terms

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- The terms for MAP members are for three years.
- The initial members will serve staggered 1-, 2-, and 3-year terms, determined by random draw at the first in-person meeting.

Committee Member Terms

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

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Establishment of the MAP Decision Making Framework

HHS Aims for the National Quality Strategy

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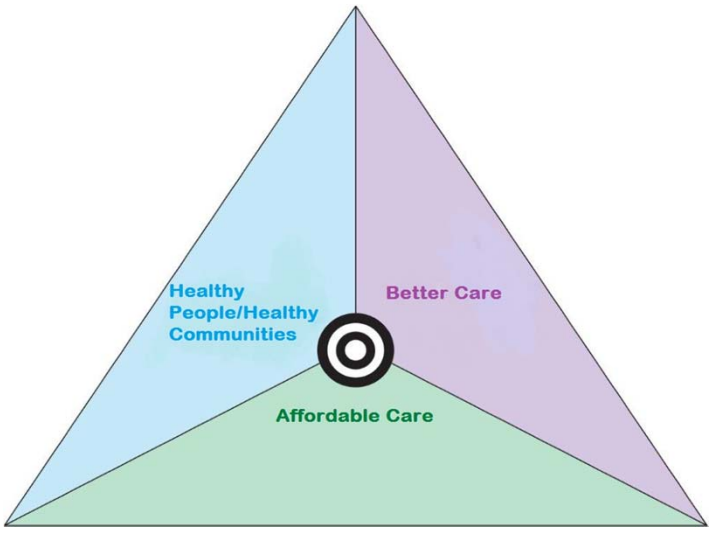

HHS National Quality Strategy

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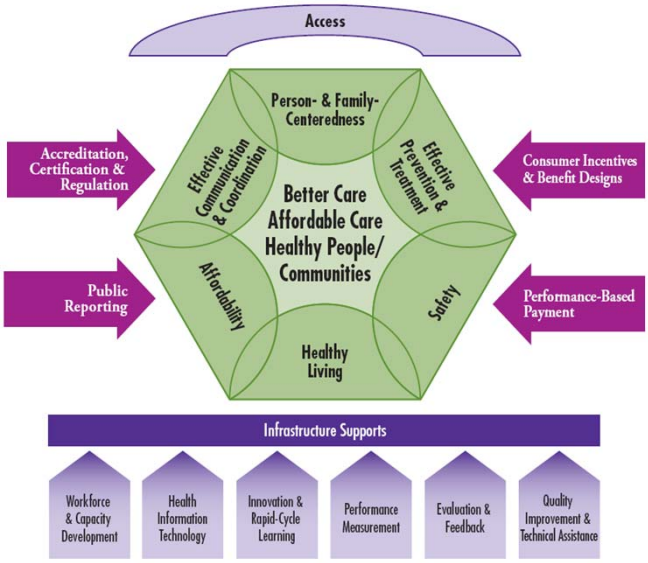

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High Impact Conditions

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Medicare Conditions

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

Child Health Conditions and Risks

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

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Patient-Focused Episodes of Care Model

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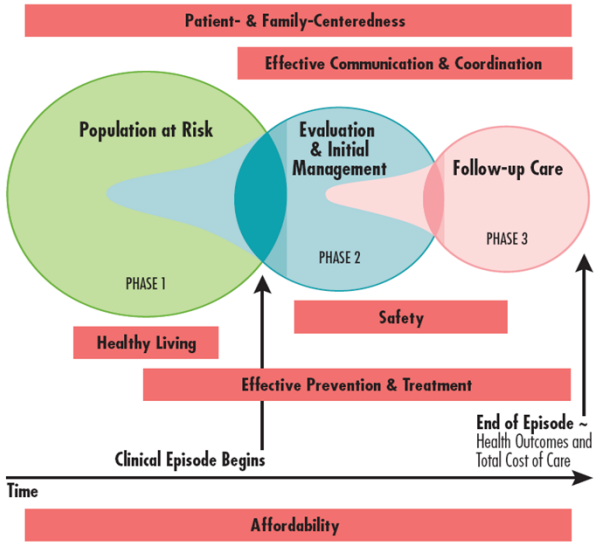

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MAP Decision-Making Framework

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

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MAP Workgroup Charges

MAP Clinician Workgroup Charge

The charge of the MAP Clinician Workgroup is to advise the Coordinating Committee on a coordination strategy for clinician performance measurement. The workgroup will:

- Identify a core set of available clinician performance measures, with a focus on:
  - Clinician measures needed across federal programs
  - Electronic data sources
  - Office setting
  - Cross cutting priorities from the NQS
  - Priority conditions
- Identify critical clinician measure development and endorsement gaps
- Develop a coordination strategy for clinical performance measurement including:
  - Alignment with other public and private initiatives
  - Health IT Implications
  - High level transition plan and timeline by month
- Provide input on measures to be implemented through the federal rulemaking process.

MAP Ad Hoc Safety Workgroup Charge

The charge of the MAP Ad Hoc Safety Workgroup is to advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions (HACs) across public and private payers. The Workgroup will:

- Review current readmission and HAC measures in use by both public and private payers.
- Identify available readmission and HAC measures:
  - In use regionally and nationally
  - Applicable across a variety of settings
  - For dual eligible beneficiaries in home and community-based service waiver programs.
- Identify critical readmission and HAC measure development and endorsement gaps.
- Develop a coordination strategy of options to ensure maximum collaboration across public and private payers, including:
  - Current and ideal approaches to measurement
  - HIT implications
  - Timeline

MAP Dual Eligible Beneficiaries Workgroup Charge

The charge of the MAP Dual Eligible Beneficiaries Workgroup is to advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The workgroup will:

- Develop a performance measurement strategy for this unique population and identify high-leverage opportunities for quality improvement
- Identify a core set of current measures that address the identified quality issues and are applicable to both specific (e.g., Special Needs Plans, PACE) and broader care models (e.g., traditional FFS, ACOs, medical homes)
- Identify gaps in available measures for the dual eligible population, and propose modifications and/or new measure concepts to fill those gaps
- Advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings

MAP Post-Acute Care/Long Term Care Workgroup Charge

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The charge of the MAP Post-Acute Care/Long-Term Care Workgroup is to advise on quality reporting for post-acute care and long-term care settings. The Workgroup will:

- Develop a coordination strategy for quality reporting that is aligned across post-acute care and long-term care settings by:
  - Identifying a core set of available measures, including clinical quality measures and patient-centered cross cutting measures
  - Identifying critical measure development and endorsement gaps
- Identify measures for quality reporting for hospice programs and facilities
- Provide input on measures to be implemented through the federal rulemaking process that are applicable to post-acute settings.

MAP Hospital Workgroup Charge

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The charge of the MAP Hospital Workgroup is to advise the Coordinating Committee on measures to be implemented through the rulemaking process for hospital inpatient and outpatient services, cancer hospitals, the value-based purchasing program, and psychiatric hospitals. The workgroup will:

- Provide input on measures to be implemented through the federal rulemaking process, the manner in which quality problems could be improved, and the related measures for encouraging improvement.
- Identify critical hospital measure development and endorsement gaps.
- Identify performance measures for PPS-exempt cancer hospital quality reporting by:
  - Reviewing available performance measures for cancer hospitals, including clinical quality measures and patient-centered cross-cutting measures
  - Identification of a core set of performance measures for cancer hospital quality reporting
  - Identification of measure development and endorsement gaps for cancer hospitals

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Stanford Input

Purpose

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

- public reporting
- payment programs
- program monitoring and evaluation

The MAP measure selection criteria will build on the NQF measure endorsement criteria.

Major Tasks

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Inventory and compare historical criteria sets, including NQF endorsement criteria; prepare comprehensive criteria set

Conduct use cases with focus on payment, reporting and program evaluation to identify measure selection criteria gaps and conflicts and approaches to resolve

Evaluate findings with key informants – users of performance accountability measures for payment, reporting, and program evaluation

Recommend measure selection criteria set for consideration by MAP Coordinating Committee

Project Methods

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Step 1: Scan existing criteria for new application-relevant concepts

- Research team scanned 35+ existing historical criteria sets to identify new concepts for application-specific measure selection criteria that are not addressed in the NQF endorsement criteria

Step 2: Perform use cases through population lens (ambulatory, inpatient, LTC, duals)

- Research team identified measures selection requirements for each setting by considering the following questions:
- a) What is the performance accountability framework for the application? Should the selection criteria domains be prioritized based on the needs of the users of the application?
- b) What methods issues are attendant to sets of measures that are aggregated for an application?
- c) Who are the audiences that will use this information? How does the information need to be organized, compiled, and reported to meet the users needs?
- d) What measurement systems are required to handle the data?
- e) Are there unique requirements for the target population, the data sources, or measure types?
- e) What is the scope/depth of the proposed measures set?

Step 3: Perform use cases through application lens (payment, reporting, monitoring)

- Key informants identify additional measure selection criteria for each of the 3 target applications
- Reconcile conflicts by adopting a "primary user" for each application and prioritizing their requirements

Step 4: Synthesize and reconcile proposed selection criteria for selection to recommend to MAP

- Research team synthesizes proposed measures selection criteria into a candidate set for applications

Project Team

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

UC Davis
- Patrick Romano, MD, MPH

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

Pacific Business Group on Health
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NEJM Article Accountability Measures: Using Measurement to Promote Quality Improvement

Tab 3

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Accountability Measures — Using Measurement to Promote Quality Improvement

Mark R. Chassin, M.D., M.P.P., M.P.H., Jerod M. Loeb, Ph.D., Stephen P. Schmaltz, Ph.D., and Robert M. Wachter, M.D.

Measuring the quality of health care and using those measurements to promote improvements in the delivery of care, to influence payment for services, and to increase transparency are now commonplace. These activities, which now involve virtually all U.S. hospitals, are migrating to ambulatory and other care settings and are increasingly evident in health care systems worldwide. Many constituencies are pressing for continued expansion of programs that rely on quality measurement and reporting.

In this article, we review the origins of contemporary standardized quality measurement, with a focus on hospitals, where such programs have reached their most highly developed state. We discuss some lessons learned from recent experience and propose a conceptual framework to guide future developments in this fast-moving field. Although many of the points we make are relevant to all kinds of quality measurement, including outcome measures, we focus our comments on process measures, both because these account for most of the measures in current use and because outcome measures have additional scientific challenges surrounding the need for case-mix adjustment. We write not as representatives of the Joint Commission articulating a specific new position of that group, but rather as individuals who have worked in the fields of quality measurement and improvement in a variety of roles and settings over many years.

A BRIEF HISTORY OF HOSPITAL QUALITY MEASUREMENT AND REPORTING IN THE UNITED STATES

Although the ubiquity of quality measurement and reporting makes it difficult to remember a health care landscape without them, these trends are remarkably recent. In 1998, the Joint Commission launched its ORYX initiative, the first national program for the measurement of hospital quality, which initially required the reporting only of nonstandardized data on performance measures.[1] In 2002, accredited hospitals were required to collect and report data on performance for at least two of four core measure sets (acute myocardial infarction, heart failure, pneumonia, and pregnancy)[2]; these data were made publicly available by the Joint Commission in 2004.

When the program started, no consensus existed regarding the kinds of measures on which data should be gathered by hospitals, no data on quality of care were collected systematically by hospitals, and little information on nationally standardized measures of hospital quality was available to the public. Few hospitals used national data on quality measures to improve clinical care processes; in fact, hospitals strongly resisted collecting data on quality measures and reporting them publicly.

The changes over the past decade have been breathtaking. The National Quality Forum has endorsed more than 600 quality measures.[3] In 2004, the Centers for Medicare and Medicaid Services (CMS) began financially penalizing hospitals that did not report to the CMS the same performance data they collected for the Joint Commission, and in 2005, the CMS began its own public reporting.[4,5] Today, hospitals provide data to the Joint Commission from a selection of 57 inpatient measures; currently, 31 of these are publicly reported, and there are plans to add the remaining, newly implemented measures over time.[6,7] The CMS also includes additional data on patient satisfaction and outcomes (death and readmissions) for common medical conditions such as pneumonia and heart failure.

THE EFFECT OF QUALITY MEASUREMENT

As we consider the effect of this new quality-measurement and reporting effort, there is much to celebrate. Many measures are quite robust, with tight, evidence-based links between process performance and patient outcomes. With the use of these measures, we have seen gratifying improvements in the performance of hospitals. For example, in 2009, a total of 98.3% of eligible patients with acute myocardial infarction received a beta-blocker at hospital discharge, as compared with 87.3% of such patients in 2002[8] (the Joint Commission's hospital performance-measure data warehouse; 2009 data will be available to the public in September 2010). Equally important, the consistency of hospital performance on key quality measures — such as prescribing beta-blockers and angiotensin-converting–enzyme inhibitors (or angiotensin-receptor blockers) to patients with an acute myocardial infarction and, in selected patients undergoing surgery, administering and discontinuing prophylactic antibiotics at the appropriate times to reduce surgical site infections — has increased dramatically in recent years (Fig. 1). For example, in 2009 (data available to the public in September 2010), 96.8% of hospitals showed performance levels greater than 90% in administering beta-blockers at discharge to patients who had had an acute myocardial infarction, as compared with 49.1% in 2002.

Because these quality-measurement and reporting programs were not implemented with the use of an experimental design, and virtually all U.S. hospitals participate in them, it is not possible to know how many of these improvements would have occurred in the absence of standardized measurement, Joint Commission accreditation requirements, public reporting, or the threat of Medicare payment penalties. On the other hand, no other national data on quality of which we are aware show such high levels of performance, nor are there other national examples of the greatly narrowed variation around high levels of performance that these data currently exhibit.

This quality-measurement and improvement effort is not without cost. Although some information can be collected relatively inexpensively from administrative data sets, many data elements — particularly those that capture the granular clinical detail that make the data credible — require painstaking and expensive review of medical records, most of which are paper records. The requirements are such that a small industry of performance-measurement–system vendors, extensively vetted and operating under stringent quality standards, supports the ORYX initiative.[9] The Joint Commission and the CMS have worked hard to ensure that in the case of the measures that are common to both programs, definitions and requirements for data collection are identical, allowing most data elements to be collected only once. ORYX vendors then submit the same data to both the Joint Commission and the CMS, satisfying both accreditation and payment requirements.[10]

In other words, over the past decade we have learned that standardized data can be collected by thousands of hospitals to identify and implement substantial improvements in care. Although measure specifications must keep up with emerging and evolving science, these challenges have not proved to be insurmountable. We believe that the "proof of concept" phase of national quality measurement and public reporting has now been completed.

ROOM FOR IMPROVEMENT

Despite the progress that has been made, even proponents of the national quality programs of the Joint Commission and the CMS identify room for improvement. To address legitimate concerns about the program, we propose that such programs now focus explicitly on maximizing health benefits to patients. Achieving this goal requires examining closely the roster of measures currently included in these programs, establishing criteria to separate measures that advance this goal from those that do not, and replacing poorly performing measures with better ones. To make these goals operational, we suggest that all quality measures used in national transparency and payment programs — both existing ones and proposed new ones — be vetted against four criteria.

First, a measure must be based on a strong foundation of research showing that the process addressed by the measure, when performed correctly, leads to improved clinical outcomes. We note here that a strong foundation means more than one study, however persuasive any single investigation might be. We do not expect that this evidence base will consist solely of data from randomized trials, though much of it will. We believe that a high bar, one that exceeds the typical standard used for the development of practice

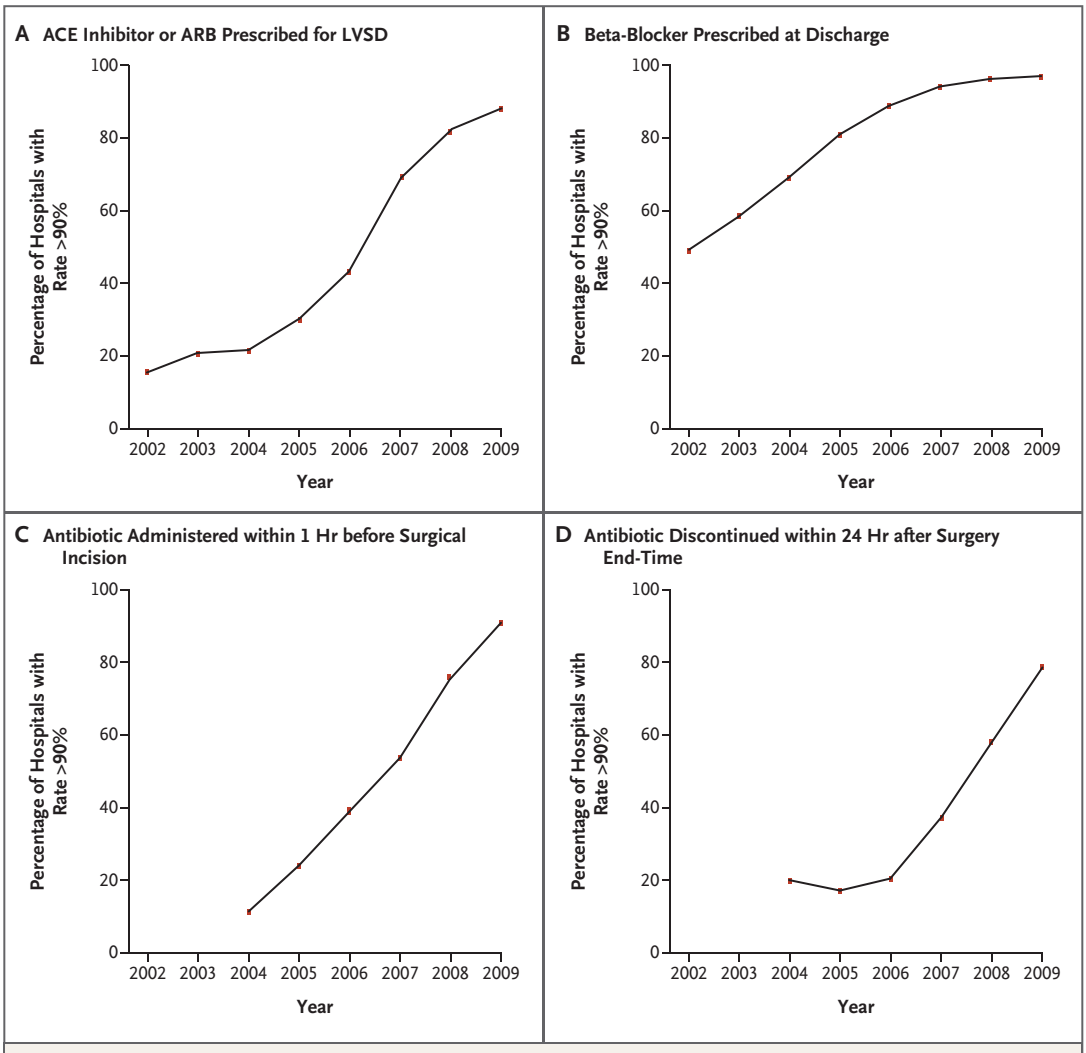

Figure 1. Performance of U.S. Hospitals on Four Publicly Reported Quality Measures.

The performance of U.S. hospitals from 2002 through 2009 on four publicly reported quality measures regarding patients with acute myocardial infarction (Panels A and B) and the appropriate administration of prophylactic antibiotics in patients undergoing surgery (Panels C and D) are shown. Two measures were chosen from the measure set for acute myocardial infarction and two from the measure set of surgical care, which began data collection in 2004. There were similar increasing trends for other measures of performance. ACE denotes angiotensin-converting enzyme, ARB angiotensin-receptor blocker, and LVSD left ventricular systolic dysfunction.

guidelines, is appropriate for measures that are used in national programs of quality measurement and improvement, since these programs affect thousands of hospitals and millions of patients. Fortunately, the state of the science has advanced to the point that we now have many measures from which to choose that meet this criterion.

Second, the measurement strategy must accurately capture whether the evidence-based care has been delivered. For example, the Joint Commission and the CMS currently measure aspirin administration after an acute myocardial infarction by reviewing a medication-administration record (or its equivalent) — a measure that genuinely captures the process of interest.[11] On the other hand, we measure the presence of comprehensive discharge planning and of smoking-cessation counseling by whether a clinician has checked off a box or otherwise documented that such activities occurred. We know that for patients with heart failure, comprehensive education at discharge and coordination of care after discharge lead to improvements in functional outcomes, reductions in emergency department vis-

Table 1. Four Criteria for Accountability Measures That Address Processes of Care.

1. There is a strong evidence base showing that the care process leads to improved outcomes.
2. The measure accurately captures whether the evidence-based care process has, in fact, been provided.
3. The measure addresses a process that has few intervening care processes that must occur before the improved outcome is realized.
4. Implementing the measure has little or no chance of inducing unintended adverse consequences.

its, and fewer hospitalizations,[12] but our current measure is incapable of judging the quality of the process (i.e., whether the process is delivered with sufficient effectiveness to make improved outcomes likely). Organizations that wish to improve their performance record may be tempted to create clever discharge-instruction forms with just the right check-boxes and printed information summaries to satisfy the chart reviewers' rules concerning compliance with the measure, instead of doing the hard work of improving their clinical care. We were, therefore, not surprised when researchers recently found no relationship between hospital performance on the discharge-instruction measure for heart failure and readmission rates.[13] We need a better measure for this important process; until we find one, measuring a check-box serves only to give us a false sense of accomplishment and reward "gaming."

Third, the measure should address a process quite proximate to the desired outcome, with relatively few intervening processes. Measures of appropriately administered medications meet this test, whereas the measure calling for an assessment of left ventricular function in patients with heart failure does not. With respect to the latter measure, although all patients with heart failure should have their ventricular function measured at some point, many other correctly performed clinical processes must occur after the test has been performed for the patient to have an improved outcome. The beneficial effect of processes as far upstream from outcomes as this one will be nullified if important processes closer to the outcome are not performed effectively. In such cases, we believe that the measurement of these processes is of little value, especially in the hospital inpatient setting. This criterion should be applied somewhat differently in ambulatory care settings, where it will be appropriate for some accountability measures to address processes that are quite upstream from outcomes, such as measures of the evidence-based use of mammography or Pap smears. Even in these cases, though, we believe that such upstream measures will be inadequate by themselves to serve as accountability measures. To provide a more complete assessment of quality, they should be coupled with measures of more downstream processes, such as the timeliness of follow-up and communication of results and the occurrence and appropriateness of definitive treatment when abnormal test results are found.

Fourth, the measure should have minimal or no unintended adverse consequences. Some evidence suggests that administering the first dose of an antibiotic to a patient with community-acquired pneumonia within the first several hours after the patient's arrival at the hospital improves outcomes.[14] However, the initial Joint Commission and CMS measure of that process (first dose of antibiotic within 4 hours [later relaxed to 6 hours] after arrival at the hospital) undoubtedly led to the inappropriate administration of antibiotics to patients who did not truly have pneumonia.[15,16] Although "diagnostic uncertainty" was added to the measure criteria as a data element, permitting hospitals to exclude some such patients, the fundamental flaw in the measure remains.[16]

In summary, measures currently used in national quality programs that do not meet the criteria for accountability measures include: three measures concerning smoking-cessation counseling — those for adults with acute myocardial infarction, adults with heart failure, and adults with pneumonia — and the measure concerning discharge instructions for patients with heart failure, because these measures fail to accurately capture the care process; a measure concerning the evaluation of left ventricular systolic function in patients with heart failure, because it is not sufficiently proximate to the outcome; and a measure calling for the initial administration of antibiotics in patients with pneumonia within 6 hours after the patient's arrival at the hospital, because it has the potential to cause adverse consequences (see Table A in the Supplementary Appendix, available with the full text of this article at NEJM.org).

A WAY FORWARD — A FOCUS ON ACCOUNTABILITY MEASURES

We believe that measures that meet all four criteria (Table 1) will have the greatest likelihood of

Table 2. Improvement in Performance on Accountability Core Measures from 2002 through 2009.*

Year	No. of Core Measures	No. of Accountability Measures	Median No. of Accountability Measures per Hospital†	No. of Hospitals Reporting†	No. of Opportunities to Provide Care in Accordance with Measures‡	Overall Performance on All Accountability Measures§	Hospitals with >90% Performance†§
						percent	
2002	16	8	5	3250	957,000	81.8	20.4
2003	16	8	5	3286	2,173,000	83.9	24.6
2004	25	16	12	3254	3,651,000	83.3	16.5
2005	25	16	12	3225	4,490,000	84.9	21.9
2006	30	20	12	3283	5,322,000	88.2	41.5
2007	34	24	12	3170	7,911,000	90.0	60.0
2008	31	22	16	3178	13,222,000	93.1	70.8
2009	31	22	16	3123	12,476,000	95.4	85.9

* Data are from the Joint Commission's hospital performance-measure data warehouse.
† For data in this column, in each year, hospitals are included only if they reported a minimum of 30 cases across all their accountability measures.
‡ The numbers in this column represent the sum of all opportunities across all hospitals and all accountability measures.
§ The temporal trends were similar when the analysis was restricted to the subgroup of 2662 hospitals that reported data on acute myocardial infarction, heart failure, and pneumonia for all 8 years.

improving patient outcomes. Therefore, although other measures may be useful for internal quality-improvement purposes, we propose that only those measures that meet all four criteria be used for purposes of accountability (e.g., for accreditation, public reporting, or pay-for-performance). Of the 28 Joint Commission 2010 core measures that are aligned with Medicare, we believe that 22 meet all four criteria and could be deemed "accountability measures" (see Table B in the Supplementary Appendix).

Achieving the goal of improving health outcomes requires, of course, that hospitals make improvements in the clinical processes of care assessed by these accountability measures. Experience to date shows that such improvement is taking place at an accelerating pace. Table 2 shows the progress that hospitals have made in improving their performance on these measures — from a performance rate of 81.8% in 2002 to a rate of 95.4% in 2009. Moreover, by 2009, among all 3123 reporting hospitals, the 22 accountability measures that were in use at that time assessed about 12.5 million opportunities to provide specific elements of evidence-based care. The percentage of hospitals whose performance across all their accountability measures exceeded 90% increased substantially — from 20.4% in 2002 to 85.9% in 2009.

CHALLENGES IN IMPLEMENTING A PROGRAM OF ACCOUNTABILITY MEASURES

Implementing these criteria presents several challenges to all the key stakeholders, but we believe that these challenges are manageable. We recognize that many current measures will not meet the stringent accountability criteria. We need to be certain that measures that do not qualify still remain available for other important purposes, when they are appropriate. For example, individual health care organizations could consider using them for their own quality initiatives. After local experimentation and modification, some may ultimately be added to the set of accountability measures.

There are other challenges as well. A narrow focus on quality measures in hospitals may miss the importance of postdischarge care for a patient — for example, a patient with heart failure. The proposed development of bundled payments and accountable care organizations may facilitate the development of inpatient and outpatient measures that are more integrated, which will be particularly useful when high-quality care requires the coordination of care across the continuum. As indicated earlier, the four criteria for accountability measures may require some adaptation for

the assessment of ambulatory care. We believe, however, that these criteria can serve as a useful framework for identifying accountability measures in nonhospital settings.

Finally, the process of improving our system of high-stakes quality measurement requires perpetual vigilance. Although some unintended adverse consequences can be anticipated and avoided during the initial evaluation of a measure, others may not become evident until many hospitals use the measures. A vital part of this program, largely absent today, will be a formal process of assessing experience with the measures and using that information to improve the development of measures and decisions regarding deployment.[16]

THE GOAL — MEASUREMENT FOR IMPROVEMENT

We call on all stakeholders that promulgate, support, or advocate for programs that use incentives of various sorts designed to promote quality in hospitals and health systems and among physicians to consider adopting this framework for accountability measures. For its part, the Joint Commission is incorporating this framework into its programs. We believe that the time is right for such a consensus to emerge. Far from the past attitude of resistance to all measurement, hospitals and physicians have embraced the measurement, and even the reporting, of robust and authentic quality metrics as an important mechanism to drive the improvement of clinical processes. In doing so, they have achieved substantial gains that have undoubtedly saved thousands of lives.

Fortunately, as the science has advanced, we now have a surfeit of measures that meet all four accountability criteria with which to populate accreditation, public reporting, and pay-for-performance programs. Eliminating measures that do not pass these accountability tests and replacing them with ones that do will reduce unproductive work on the part of hospitals, enhance the credibility of the program with physicians and other key stakeholders, and increase the positive effect that all these programs will have on health outcomes for patients.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMsb1002320) was published on June 23, 2010, at NEJM.org.

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IOM Article

Child and Adolescent Health and Health Care Quality

Tab 4

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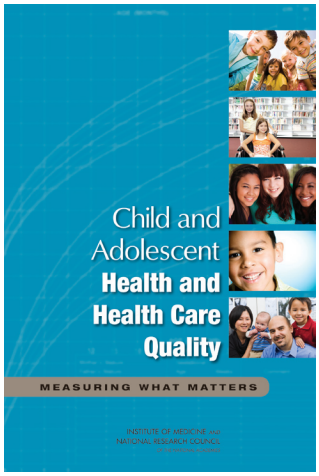
Child and Adolescent Health and Health Care Quality

Measuring What Matters



Health and health care quality measures can provide valuable information about the health status of children and adolescents, as well as the outcomes associated with medical care, policy, and social programs. These measures are especially useful in monitoring general health and health care trends as well as identifying disparities among disadvantaged populations. Despite the fact that the U.S. government currently supports hundreds of data sets and measures through federal surveys and administrative data systems, the United States lacks robust national- and state-level information about the health status or health care quality of children and adolescents, particularly in areas that could provide guidance to policy makers and health care providers.

In the *Children's Health Insurance Program Reauthorization Act of 2009*, Congress directed the Institute of Medicine (IOM) and the National Research Council (NRC) to evaluate the state of efforts to measure child and adolescent health and the quality of their health care services. The IOM and the NRC formed the Committee on Pediatric Health and Health Care Quality Measures, which reviewed hundreds of population surveys, such as census records and health surveys, and administrative data sets, such as those based on payment and health records.

Currently, there is no single data source that can provide valid and reliable indicators about the health and health care quality of children and adolescents.

The Nature, Scope, and Quality of Existing Data Sources

Currently, there is no single data source that can provide valid and reliable indicators about the health and health care quality of children and adolescents. Policy makers and researchers therefore must examine data from a variety of federal and state data sources to get a clear picture of child and

adolescent health and the quality of health care they receive. The committee concludes that a lack of standardization in key areas—such as race and ethnicity, socioeconomic status, primary language spoken at home, and parental English proficiency—limits the ability of those who use data to identify, monitor, and address persistent health and health care quality disparities among children and adolescents. Measurement in these areas is especially important given the growing ethnic and racial diversity of children and adolescents and the increasing number of children who live in poverty. The U.S. Department of Health and Human Services (HHS) should provide leadership to standardize data in key areas, including developing precise definitions and utilizing consistent data collection methods.

Gaps in Measurement Areas

Research shows that physical and social environments (for example, safe neighborhoods or crowded housing), personal health behaviors, and social relationships (for example, parent-child attachment) influence the health status of children and adolescents and their use of health care services. These contextual factors have significant effects on the short- and long-term health outcomes of children and adolescents, yet information about them often is lacking in existing data sets.

Another significant gap is the general absence of information about the content and quality of preventive services that are used by children and adolescents. This information is especially relevant because screening and early interventions may mitigate serious health disorders later in life.

A life-course approach to measurement is one new strategy to closing the gaps in measuring child and adolescent health and health care quality. This approach, which considers how events at each stage of life influence subsequent health and health care quality, is particularly important in developing measures for children and adolescents. This approach to measurement will focus on the needs of the "whole child" as opposed to individual clinical concerns and will better address the distinct needs of younger populations, including their unique patterns of morbidity and mortality, their dependent status, and their developmental stages. Measuring transitions of care between primary care and specialty care also is important, especially for children with special health care needs.

Methodological Areas that Deserve Attention

The committee endorses the use of innovative measurement practices that can adapt to changing conditions, changing populations, and opportunities for health improvement. This will require efforts that track key child and adolescent populations over time to ensure that groups with the greatest risk for poor outcomes are included in the relevant data sources. To facilitate innovation in measurement, the strengths and limitations of different surveys need to become more transparent.

In some cases, HHS can link or aggregate multiple data sources—connecting one database to another, for example—and therefore reduce the burden of data collection on individual states, providers, health plans, and households. Longitudinal studies, which include multiple observations for the same children/families over time, also would enrich the quality of indicators. And the capture of electronic data offers opportunities to enhance future measurement activity. Such efforts need to offer protections for privacy and confidentiality. They also have the potential to capture important state-level policy and community-level characteristics and enable analysis of the variability and impact of coverage, eligibility, and payment policies.

A life-course approach to measurement is one key strategy to closing the gaps in measuring child and adolescent health and health care quality. This approach, which considers how events at each stage of life influence subsequent health and health care quality, is particularly important in developing measures for children and adolescents.

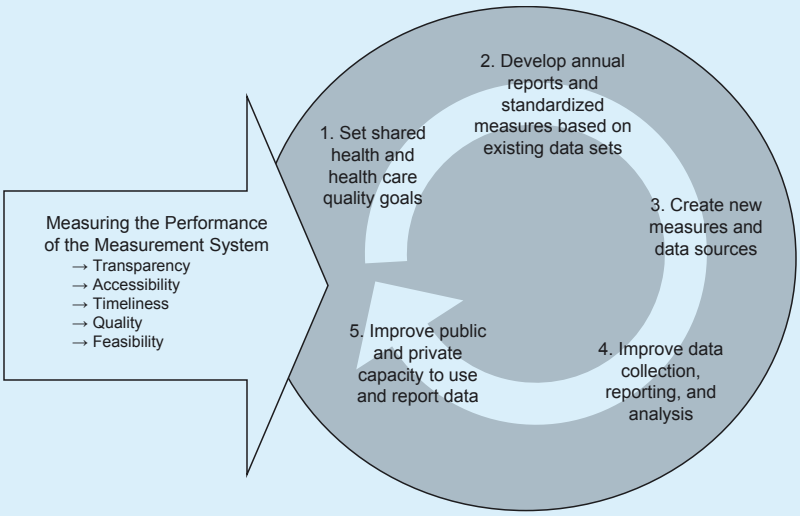
A Stepwise Approach

The committee recommends a stepwise approach (see Figure 1) for improving data sources and measures of health and health care quality for children and adolescents. This approach is designed to stimulate and support collaborative efforts among federal and state agencies and key stakeholder groups through the following five steps:

1. Set shared health and health care quality goals for children and adolescents in the United States
2. Develop annual reports and standardized measures for existing data sets of health and health care quality that can be collected and used to assess progress toward those goals
3. Create new measures and data sources in priority areas
4. Improve methods for data collection, reporting, and analysis
5. Improve public and private capacities to use and report data

This stepwise approach is necessarily continuous and calls for the evaluation of the measurement system itself for transparency, accessibility, timeliness, quality, and feasibility. The entire approach will be informed by private initiatives as well as government–sponsored efforts. This approach is meant to align existing and future efforts to measure health and health care qual-

Figure 1: A Stepwise Approach to Measuring Health and Health Care Quality for Children and Adolescents



SOURCE: Committee on Pediatric Health and Health Care Quality Measures, 2011

ity for children and adolescents. Some improvements to measurement can be made immediately under the leadership of the Secretary of HHS; others require longer-term consensus-building efforts among multiple federal agencies.

Conclusion

Improving health outcomes for children and adolescents is essential to achieving a healthy future for the nation. A life-course approach to the measurement of health and health care quality, with new emphasis on the social and behavioral determinants of health and monitoring disparities in health and health care quality, will deepen understanding of key opportunities to achieve these outcomes.

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MAP Schedule of Deliverables

Tab 5

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

MAP Workgroups Chart

Tab 6

Measures Application Partnership (MAP) Clinician Workgroup

Convened by the National Quality Forum

<table>
<tr><td>Goal</td><td colspan="2">Provide input to HHS on a coordination strategy for clinician performance measurement across public programs</td></tr>
<tr><td>Step 1:
Clinician Workgroup
June 7-8, 2011</td><td colspan="2">Develop Elements of a Coordination Strategy
Measures and measurement issues
Data source and HIT implications
Alignment with other settings
Special considerations for dual eligible beneficiaries
Pathway for improving measure application</td></tr>
<tr><td>Step 2:
Clinician Workgroup
June 7-8, 2011</td><td colspan="2">Review Current Clinician Performance Measurement Programs and Measures Currently In Use</td></tr>
<tr><td></td><td><u>Federal Programs Included in Coordination Strategy</u>
Physician Quality Reporting System (PQRS)
E-Prescribing Incentive Program
Electronic Health Records – Meaningful Use
Physician Feedback/Value Modifier [Previously called The Physician Resource Use Measurement and Reporting (RUR) Program]
Physician Compare</td><td><u>Programs For Additional Consideration</u>
Medicare Advantage/5-star rating
CHIPRA Initial Core Set Measures
Medicaid Core Measure Set
ACO Proposed Regulations
IHA (Integrated Healthcare Association – California Pay for Performance Program)
Blue Cross Blue Shield of Massachusetts Alternative Quality Contract</td></tr>
<tr><td>Step 3:
MAP Coordinating Committee
June 21-22, 2011</td><td colspan="2">Guidance from MAP Coordinating Committee
Coordination strategy elements
Measure selection principles
Opportunities for alignment
Challenges in transitioning from the current to the ideal state</td></tr>
</table>

Step 4: Clinician Workgroup July 13-14, 2011	**Develop a Coordination Strategy for Clinician Performance Measurement**
Step 5: MAP Coordinating Committee August 17-18, 2011	**MAP Coordinating Committee to Review and Finalize Report on Coordination Strategy for Clinician Performance Measurement**

Measures Application Partnership (MAP) Ad Hoc Safety Workgroup

Convened by the National Quality Forum

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

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

	Measures would ideally be suitable for multiple purposes • Driving improvement vs. public reporting vs. payment		
Step 3: MAP Coordinating Committee June 21-22, 2011	**Guidance from the MAP Coordinating Committee** • Are there additional considerations related to the 3 dimensions (collaboration with purchasers and providers, promising program features, and measure characteristics) identified for payer alignment? • Are there other opportunities for alignment beyond those identified by the Safety Workgroup? • As the Safety Workgroup further develops a payer coordination strategy for implementation, are there specific practical considerations the Workgroup should take into account?		
Step 4: Ad Hoc Safety Workgroup July 11-12, 2011	**Develop a Coordination Strategy for Addressing Readmissions and HACs Across Public and Private Payers**		
Step 5: MAP Coordinating Committee August 17-18, 2011	**Review and Finalization of the Coordination Strategy by the Coordinating Committee**		

Measures Application Partnership (MAP) Dual Eligible Beneficiaries Workgroup

Convened by the National Quality Forum

Goal	**Advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries**
Step 1: Dual Eligible Beneficiaries Workgroup June 2-3, 2011	**Develop Guiding Principles and Strategic Approach to Performance Measurement** In considering a strategic approach to performance measurement for the care of individuals eligible for both Medicare and Medicaid, the workgroup identified a number of themes. • *Vision*: Individuals should have reliable access to a person-centered, culturally competent support system that helps them in reaching their personal goals through access to a range of healthcare services and community resources • The population is defined by its heterogeneity and diversity; the group is best segmented by functional status or position on a trajectory spanning from health/wellness to disability/illness • Culturally competent care must incorporate many dimensions, including race/ethnicity, language, level of health literacy, accessibility of the environment for people with disability, etc. • Strategy for performance measurement should emphasize data exchange through portable, interoperable electronic health records with ways to gather/share information with the beneficiary, feedback to providers in order to facilitate continuous improvement, and a risk adjustment strategy to mitigate potential unintended consequences (e.g., adverse selection, overuse) • The workgroup identified significant research needs and gaps in information related to quality of care for specific subpopulations (e.g., high cost/high need patients, patient-reported outcomes)

Step 2:
Dual Eligible Beneficiaries Workgroup
June 2-3, 2011
	Identify High-Leverage Quality Improvement Opportunities for the Population
	The workgroup identified many opportunities for improving quality through performance measurement. The three areas initially prioritized by the group are:
	• Care coordination
	  ○ Should take place across and within settings where care and community support is provided, across provider types, and across Medicare and Medicaid benefit structures
	  ○ Include process measures, such as presence of a person-centered plan of care and medication reconciliation

	○ Include measures of access to multi-disciplinary team to provide care and support ○ Include measures related to advance planning and/or palliative care • Quality of life ○ Care and supports are provided to enhance quality of life and enable individual to reach his/her self-determined goals ○ Include measures of functional status, to be evaluated over time ○ Include measures of an individual's ability to participate in his/her community • Screening and assessment ○ Screening should be thorough and tailored to address the many complexities of the dual eligible beneficiary population in order to enable effective care ○ Assess home environment and availability of family and community supports ○ Screen for underlying mental and cognitive conditions, drug and alcohol history, HIV status, risk of falling, etc.
Step 3: MAP Coordinating Committee June 21-22, 2011	**Guidance from the MAP Coordinating Committee** • Guidance or additional input related to the workgroup's vision for high-quality care, guiding principles, or initial considerations for a performance measurement strategy • Guidance or additional input related to the identified high-leverage opportunities for improvement
Step 4: Dual Eligible Beneficiaries Workgroup July 25-26, 2011	**Refine Strategic Approach and High-Leverage Opportunities** • Continue discussion of strategic approach and high-leverage opportunities; incorporate Coordinating Committee guidance • Consider data source/HIT implications and methodological issues • Align with other ongoing initiatives (e.g. framework for measuring multiple chronic conditions)

Step 5: Dual Eligible Beneficiaries Workgroup July 25-26, 2011	**Match Current Measures to Identified Opportunities** • Identify measure sets currently in use in the Medicare and Medicaid programs • Gather current measures that apply to high-leverage opportunities identified by the workgroup • Assess selected measures for appropriateness of use in dual eligible population
Step 6: MAP Coordinating Committee August 17-18, 2011	**MAP Coordinating Committee Review and Approval** • Coordinating Committee reviews themes and initial recommendations for interim report on proposed performance measurement strategy for dual eligible beneficiaries
Step 7: Dual Eligible Beneficiaries Workgroup Ongoing through June 1, 2012	**Continued Refinement of Strategy and Recommendations** • Incorporate HHS and public comment on interim report • Continue mapping measures currently in use to identified high-leverage opportunities for quality improvement • Refine potential core measure set, identify gaps in available measures, and propose modifications and/or new measure concepts to fill gaps • Discuss transition plans and path forward

MAP Workgroup Initial Findings: Cross Cutting Themes

Tab 7

MAP Workgroup Initial Findings: Cross-Cutting Themes

		Clinician	Ad Hoc	Duals	NPP
Key considerations for measurement strategy	Communication/coordination across settings & into community	✓	✓	✓	BC
	Shared decisionmaking	✓		✓	BC
	Functional status	✓		✓	BC & HP
	Patient reported outcomes	✓		✓	BC & HP
	Quality of life/well-being	✓		✓	BC & HP
	Health literacy (care instructions understandable)		✓	✓	BC & HP
	Access to community/caregiver supports		✓	✓	BC & HP
	Medication adherence/reconciliation		✓	✓	BC
	Access to quality care		✓		BC & HP
	Care plan developed & followed			✓	BC
	Depression/mental health screening			✓	HP
	Culturally sensitive care			✓	BC & HP
	Patient experience			✓	BC
Key programmatic considerations	Transparency	✓	✓	✓	BC & HP
	Level of analysis	✓	✓	✓	
	Considering shared accountability/"teamness"	✓	✓	✓	BC
	Considering unintended consequences	✓	✓		BC & HP
	Using HIT tools	✓		✓	BC
	Using disparities lens		✓	✓	BC & HP
	Based on multiple chronic conditions framework when necessary			✓	BC

*Note: BC =Better Care Subcommittee; HP = Healthy People/Healthy Communities Subcommittee

MAP Communication Slides

Tab 8

Measure Applications Partnership Overview

What is MAP?

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum.

MAP was created for the explicit purpose of providing input to the Department of Health and Human Services on the selection of performance measures for public reporting and performance-based payment programs.

Statutory Authority

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

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

Why is MAP Important?

- From the universe of measures, MAP can help users pick the right ones for their specific applications.
- MAP is designed to support broader national efforts to create better, more affordable care.

MAP Function

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

Measure Recommendations

- MAP will recommend the best measures available for specific uses, giving first consideration to NQF-endorsed measures.
- When non-endorsed measures are selected, the measure developer will be asked to submit the measure to an NQF endorsement project for consideration.
- Gaps identified in the portfolio of endorsed measures will be captured to inform subsequent measure development.

Potential Benefits

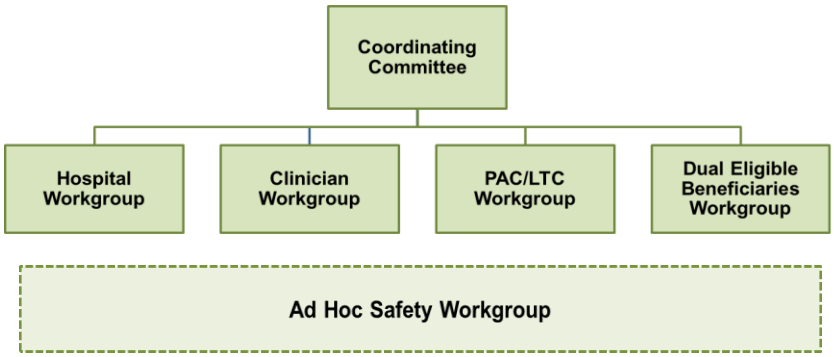
- Strengthen public reporting
- Provide people with more and better information for making healthcare choices
- Help providers improve their performance
- Reduce data collection burden through the alignment of measurement activities
- Shape payment programs, creating powerful financial incentives to providers to improve care
- Align care delivery across settings and providers

Unique Attributes of MAP

- MAP participants include consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers ensuring that HHS will receive well-rounded input on performance measure selection.

- Consumer and purchaser stakeholders will have a place and a voice in every discussion.

MAP 2-Tiered Structure



More than 60 organizations representing major stakeholder groups, 40 individual experts, and nine federal agencies are represented in the Coordinating Committee and workgroups.

MAP Work Reflects National Priorities

- The MAP decision-making framework includes priorities from:
  - National Quality Strategy
  - Partnership for Patients safety initiative
  - high-priority Medicare and child health conditions, and
  - the patient-focused episodes of care model.

Additionally, the Coordinating Committee will develop measure selection criteria to help guide MAP decision making.

MAP Coordinating Committee Charge

NQF National Quality Forum

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

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

MAP Clinician Workgroup Charge

NQF National Quality Forum

The charge of the MAP Clinician Workgroup is to advise the Coordinating Committee on a coordination strategy for clinician performance measurement. The Workgroup will:

- Identify a core set of available clinician performance measures, with a focus on:
  - Clinician measures needed across Federal programs;
  - Electronic data sources;
  - Office setting;
  - Cross cutting priorities from the NQS; and
  - Priority conditions.
- Identify critical clinician measure development and endorsement gaps
- Develop a coordination strategy for clinical performance measurement including:
  - Alignment with other public and private initiatives;
  - HIT Implications;
  - High level transition plan and timeline by month
- Provide input on measures to be implemented through the Federal rulemaking process

MAP Coordinating Committee Membership

NQF National Quality Forum

Co-chairs	George Isham, MD, MS
	Elizabeth McGlynn, PhD, MPP

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

MAP Coordinating Committee Membership

NQF National Quality Forum

Subject Matter Experts	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	Agency for Healthcare Research and Quality	Federal Government Representative: Nancy J. Wilson, MD, MPH
	Centers for Disease Control and Prevention	Chesley Richards, MD, MPH
	Centers for Medicare & Medicaid Services	Karen Milgate, MPP
	Health Resources and Services Administration	Victor Freeman, MD, MPP
	Office of Personnel Management/FEHBP	John O'Brien
	Office of the National Coordinator for HIT	Thomas Tsang, MD, MPH
Accreditation / Certification Liaisons	American Board of Medical Specialties	Accreditation / Certification Liaison Representative: Christine Cassel, MD
	National Committee for Quality Assurance	Peggy O'Kane, MPH
	The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH

MAP Dual Eligible Beneficiaries Workgroup Charge

NQF National Quality Forum

The charge of the MAP Dual Eligible Beneficiaries Workgroup is to advise the MAP Coordinating Committee on performance measures to assess and improve the quality of care delivered to Medicare/Medicaid dual eligible beneficiaries. The Workgroup will:

- Develop a strategy for performance measurement for this unique population and identify the quality improvement opportunities with the largest potential impact.
- Identify a core set of current measures that address the identified quality issues and are applicable to both specific (e.g., Special Needs Plans, PACE) and broader care models (e.g., traditional FFS, ACOs, medical homes).
- Identify gaps in available measures for the dual eligible population, and propose modifications and/or new measure concepts to fill those gaps.
- Advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions across public and private payers and on pre-rulemaking input to HHS on the selection of measures for various care settings.

MAP Hospital Workgroup Charge

NQF National Quality Forum

The charge of the MAP Hospital Workgroup is to advise the Coordinating Committee on measures to be implemented through the rulemaking process for hospital inpatient and outpatient services, cancer hospitals, the value-based purchasing program, and psychiatric hospitals. The Workgroup will:

- Provide input on measures to be implemented through the Federal rulemaking process, the manner in which quality problems could be improved, and the related measures for encouraging improvement.
- Identify critical hospital measure development and endorsement gaps.
- Identify performance measures for PPS-exempt cancer hospital quality reporting by:
  - Reviewing available performance measures for cancer hospitals, including clinical quality measures and patient-centered cross-cutting measures;
  - Identification of a core set of performance measures for cancer hospital quality reporting; and
  - Identification of measure development and endorsement gaps for cancer hospitals.

MAP Post-Acute/Long-Term Care Workgroup Charge

NQF National Quality Forum

The charge of the MAP Post-Acute Care/Long-Term Care Workgroup is to advise on quality reporting for post-acute care and long-term care settings. The Workgroup will:

- Develop a coordination strategy for quality reporting that is aligned across post-acute care and long-term care settings by:
  - Identifying a core set of available measures, including clinical quality measures and patient-centered cross cutting measures; and
  - Identifying critical measure development and endorsement gaps.
- Identify measures for quality reporting for hospice programs and facilities;
- Provide input on measures to be implemented through the Federal rulemaking process that are applicable to post-acute settings.

MAP Ad Hoc Safety Workgroup Charge

NQF National Quality Forum

The charge of the MAP Ad Hoc Safety Workgroup is to advise the Coordinating Committee on a coordination strategy for measuring readmissions and healthcare-acquired conditions (HACs) across public and private payers. The Workgroup will:

- Review current readmission and HAC measures in use by both public and private payers.
- Identify available readmission and HAC measures:
  - In use regionally and nationally;
  - Applicable across a variety of settings
  - For dual eligible beneficiaries in home and community-based service waiver programs.
- Identify critical readmission and HAC measure development and endorsement gaps.
- Develop a coordination strategy of options to ensure maximum collaboration across public and private payers, including:
  - Current and ideal approaches to measurement,
  - HIT implications, and
  - Timeline.

How to Engage with the MAP

NQF
National Quality Forum

- NQF Website, www.qualityforum.org is central place to track MAP activities and progress

- Transparent Work Environment
  - In-person and web-based meetings open to the public
  - Public comment periods

MAP Coordinating Committee Bios

Tab 9

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Bios of the MAP Coordinating Committee

Co-Chairs (voting)

George J. Isham, MD, MS

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

Elizabeth A. McGlynn, PhD, MPP

Elizabeth A. McGlynn, PhD, is the director for the Center of Effectiveness and Safety Research (CESR) at Kaiser Permanente. She is responsible for oversight of CESR, a network of investigators, data managers and analysts in Kaiser Permanente's regional research centers experienced in effectiveness and safety research. The Center draws on over 400 Kaiser Permanente researchers and clinicians, along with Kaiser Permanente's 8.6 million members and their electronic health records, to conduct patient-centered effectiveness and safety research on a national scale. Kaiser Permanente conducts more than 3,500 studies and its research led to more than 600 professional publications in 2010. It is one of the largest research institutions in the United States. Dr. McGlynn leads efforts to address the critical research questions posed by Kaiser Permanente clinical and operations leaders and the requirements of the national research community. CESR, founded in 2009, conducts in-depth studies of the safety and comparative effectiveness of drugs, devices, biologics and care delivery strategies. Prior to joining Kaiser Permanente, Dr. McGlynn was the Associate Director of RAND Health and held the RAND Distinguished Chair in Health Care Quality. She was responsible for strategic development and oversight of the research portfolio, and external dissemination and communications of RAND Health research findings. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness and technical quality of health care delivery. She has conducted research on the appropriateness with which a variety of surgical and diagnostic procedures are used in the U.S. and in other countries. She led the development of a comprehensive method for evaluating the technical quality of care delivered to adults and children. The method was used in a national study of the quality of care delivered to U.S. adults and children. The article reporting the adult findings received the Article-of-the-Year award from AcademyHealth in 2004. Dr. McGlynn also led the RAND Health's COMPARE initiative, which developed a comprehensive method for evaluating health policy proposals. COMPARE developed a new microsimulation model to estimate the effect of coverage expansion options on the number of newly insured, the cost to the government, and the effects on premiums in the private sector. She has conducted research on efficiency

measures and has recently published results of a study on the methodological and policy issues associated with implementing measures of efficiency and effectiveness of care at the individual physician level for payment and public reporting. Dr. McGlynn is a member of the Institute of Medicine and serves on a variety of national advisory committees. She was a member of the Strategic Framework Board that provided a blueprint for the National Quality Forum on the development of a national quality measurement and reporting system. She chairs the board of AcademyHealth, serves on the board of the American Board of Internal Medicine Foundation, and has served on the Community Ministry Board of Providence-Little Company of Mary Hospital Service Area in Southern California. She serves on the editorial boards for *Health Services Research* and *The Milbank Quarterly* and is a regular reviewer for many leading journals. Dr. McGlynn received her BA in international political economy from Colorado College, her MPP from the University of Michigan's Gerald R. Ford School of Public Policy, and her PhD in public policy from the Pardee RAND Graduate School.

Organizational Members (voting)

AARP
Joyce Dubow, MUP
Ms. Dubow is Senior Health Care Reform Director in AARP's Office of the Executive Vice- President for Policy and Strategy, where she has responsibility for a broad health portfolio related to AARP's health care reform initiatives with a special focus on health care quality, HIT, and consumer decision making, as well as private health plans in the Medicare program. Dubow serves on several multi-stakeholder groups focusing on quality improvement. She was the first chair (and continues to be a member) of the Consensus Standards Approval Committee (CSAC) of the National Quality Forum. She is a member of the National Committee for Quality Assurance's Committee on Physician Programs and its Measurement Panel on Geriatrics; the National Advisory Committee for Aligning Forces for Quality of the Robert Woods Johnson Foundation; the National Committee on Evidence-based Benefit Design of the National Business Group on Health; the National Heart Lung Blood Institute Cardiovascular Disease Clinical Guideline Expert Panel and the National Advisory Board of the Practice Change Fellows Program. She also participates in the Hospital Quality Alliance, the AQA Steering Committee, the Markle Foundation's Connecting For Health program, as well as other ad hoc groups focusing on health care quality and consumer decision making. In a "former life," Ms. Dubow was the executive vice-president of the Georgetown University Community Health Plan, a university-sponsored prepaid group practice plan. She was also the Director of Policy and Legislation in the federal Office of Health Maintenance Organizations. Ms. Dubow holds a B.A. in Political Science from the University of Michigan and a Masters in Urban Planning from Hunter College of the University of the City of New York.

Academy of Managed Care Pharmacy
Judith A. Cahill
As Executive Director of the Academy of Managed Care Pharmacy, Judy Cahill has responsibility for policy creation and implementation, administrative operations, and overall staff leadership of the Academy of Managed Care Pharmacy (AMCP). The Academy is a professional society with over 6,000 members nationwide which is dedicated to the continuing professional development of pharmacists and other health care practitioners engaged in the practice of pharmacy in managed care settings. Ms. Cahill has guided the Academy's ground breaking work on *AMCP's Format for Formulary Submissions* and its most recent electronic iteration, the AMCP eDossier System. Under her guidance, the Academy has issued the continuous quality improvement tool for pharmacy, *AMCP's Framework for Quality Drug Therapy.* Judy has been working in the dynamic area of managed health care for over 25 years. For 11 years she helped direct the activities of the Group Health Association of America, the leading trade association representing health maintenance organizations in the United States. Prior to her duties with

GHAA, Ms. Cahill served as contracting officer for the HMOs that participated in the United States Federal Employees Health Benefits Program. Ms. Cahill holds a Bachelor of Arts degree from LeMoyne College, a Masters of Arts degree from the University of Cincinnati, and certification as an Employee Benefits Specialist from the Wharton School of Business. She serves on several editorial advisory boards and Boards of Directors for organizations dedicated to serving the pharmacy profession. Those appointments include as Chair of the Pharmacy Quality Alliance Board of Directors and as a voting member of the National Quality Forum's Measurement Applications Partnership Coordinating Committee.

AdvaMed
Michael Mussallem
Michael A. Mussallem is chairman and chief executive officer of Edwards Lifesciences Corporation, the global leader in the science of heart valves and hemodynamic monitoring. Driven by a passion to help patients, the company partners with clinicians to develop innovative technologies in the areas of structural heart disease and critical care monitoring that enable them to save and enhance lives. Mussallem has headed Edwards Lifesciences since it was spun off from Baxter International Inc. and began operating as an independent, publicly traded company (NYSE:EW) in April 2000. Previously, he was responsible for the worldwide operations of both Baxter's CardioVascular business, which he had headed since 1995, and its Biopharmaceuticals business, which he had been appointed to lead in 1998. Mussallem joined Baxter in 1979 and progressed through a variety of increasingly responsible positions in manufacturing, engineering and product development. He was named president of Baxter's Critical Care Division in 1993, and group vice president of Baxter's Surgical Group in 1994. From 1996 through 1998, he chaired Baxter's Asia-Pacific Board, which coordinated all of Baxter's regional initiatives. Previously, he worked for Union Carbide. Mussallem is the former chairman of the board of directors of the Advanced Medical Technology Association (AdvaMed). He is currently on the boards and executive committees of AdvaMed, California Healthcare Institute and OCTANe, and is a trustee of the University of California, Irvine Foundation. Mussallem received a bachelor's degree in chemical engineering and an honorary doctorate from the Rose-Hulman Institute of Technology in Terre Haute, Indiana.

AFL-CIO
Gerald Shea
As Assistant to the President at the AFL-CIO since 1995, Gerald M. Shea's work covers issues such as health care and retirement security as well as relations with allied organizations and government entities. In that position, Shea manages the work of the AFL-CIO on all aspects of healthcare. Through his work, he represents the experience and perspective of workers as health care consumers in various policy organizations and health events. Shea is a member of the Board of the National Quality Forum (NQF), the Board of the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), of the Hospital Quality Alliance, and the Quality Alliance Steering Committee. He was a founding board member of the Foundation for Accountability (FACCT), Health Care for America NOW and the RxHealthValue Project. He is a past member of the Social Security Advisory Board, the Medicare Prospective Payment Advisory Commission (MedPAC) and its predecessor, the Prospective Payment Advisory Commission. Before his appointment in 1995, Shea held various positions at the AFL-CIO from August 1993 through October 1995; as director of the policy office with responsibility for health care and pensions and then in several executive staff positions. Prior to joining the AFL-CIO, Shea spent 21 years with the Service Employees International Union as an organizer and local union official in Massachusetts and as a member of SEIU's senior staff in Washington, D.C. Shea is a native of Massachusetts and a graduate of Boston College.

NATIONAL QUALITY FORUM

America's Health Insurance Plans
Aparna Higgins, MA
Ms. Higgins is Vice President, Private Market Innovations at America's Health Insurance Plans (AHIP), where she is focused on a number of key initiatives including performance measurement, innovative payment models and delivery system reform. She led AHIP Foundation's efforts to pilot-test a data aggregation methodology, a component of the High-Value Health Care project funded by the Robert Wood Johnson Foundation, for individual physician performance measurement across regions and health plans. She is a healthcare economist with expertise and experience in study design and economic modeling and has directed a number of research and analytic projects employing multi-disciplinary teams. She serves on a number of expert panels on performance measurement. Prior to AHIP, she was at Booz Allen Hamilton where she led a team of health services researchers focused on studies related to electronic health record (EHR) adoption, quality measurement, and value-based purchasing. She was the principal investigator for two research studies on physician adoption of EHRs and evaluation design of the business case for Health Information Technology (HIT) in Long-Term Care for the Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE). She played a key leadership role in assisting the Centers for Medicare and Medicaid Services (CMS) with the design of a Medicare Hospital Value-based purchasing (VBP) program and was closely involved in developing the hospital VBP report to Congress.

American College of Physicians
David W. Baker, MD, MPH, FACP
David W. Baker, MD, MPH is Michael A. Gertz Professor in Medicine and Chief of the Division of General Internal Medicine, Northwestern University. He received his MD from the UCLA School of Medicine and his MPH from the UCLA School of Public Health. He completed his research training in the UCLA Robert Wood Johnson Clinical Scholars' Program. His research has focused on access to health care, racial and ethnic disparities in care, health communication, and quality of care for chronic diseases. He has led studies examining many aspects of quality, including whether hospital mortality "report cards" lead to changes in market share for hospitals and improvements in outcomes, the effect of disease management programs for patients with heart failure, and an evaluation of the Institute for Healthcare Improvement's Improving Chronic Illness Care Collaborative. His current work is examining quality measurement and quality improvement using electronic health record systems. Dr. Baker has served in many national roles as well. He served as the Associate Project Director for the AHCPR-funded Heart Failure guideline and was lead author for a series of manuscripts in JAMA on quality of care for patients with heart failure. He has served as an advisor to both the Ohio and the Georgia Peer Review Organizations' heart failure quality improvement projects, and he was part of the American Heart Association's first working group for measuring quality of care and outcomes for cardiovascular disease. He served on the American College of Cardiology/American Heart Association Heart Failure Practice Guideline committee and the American Board of Internal Medicine's Committee for their new Heart Failure Practice Improvement Module. He has served as a member of the Health Information Technology Expert Panel's (HITEP) Quality Data Set subcommittee. He currently serves on the Physicians' Consortium for Performance Improvement (PCPI) Measure Implementation and Evaluation subcommittee and the American College of Physicians' Performance Measure Advisory Committee.

American College of Surgeons
Frank G. Opelka, MD, FACS
Frank G. Opelka, MD FACS is the Vice Chancellor for Clinical Affairs and Professor of Surgery at Louisiana State University Health Sciences Center in New Orleans. In LSU, he actively teaches in the 4 health sciences schools developing programs for innovation and delivery system redesign. He also works at the LSU seven hospital system to support efforts for the development of a safety net ACO to address various challenges such as the dual eligible. He also represents the American College of Surgeons,

Washington DC Office in the Division of Health Policy and Advocacy. Dr. Opelka founded and serves as the chair of the Surgical Quality Alliance, with over 20 surgical organizations sitting in the alliance. He serves as one of the original members of the National Priorities Partnership in the National Quality Forum, a member of the NQF's Consensus Standards Advisory Committee, and has served as a chair of an NQF steering committee. Dr. Opelka continues to serve on the Quality Alliance Steering Committee, the AQA, and the AMA's Physician Consortium for Performance Improvement. He has served on several advisory committees to several health plans, including United Health Group, Blue Cross Blue Shield of America, and Humana. Dr. Opelka has developed and assisted the American Board of Medical Specialties in their clinical registry efforts for the Maintenance of Certification Part IV. Prior to serving in the quality arena, Dr. Opelka worked closely with CMS in the Ambulatory APG relative values, AMA's Relative Value Updates Committee, Practice Expense Committee, and an advisory to the CPT Editorial Committee. Dr. Opelka served 12 years on active duty in the US Army where he did his residency in General Surgery at the Walter Reed Army Medical Center and Eisenhower Army Medical Center. His colorectal surgery fellowship was at the Ochsner Clinic New Orleans where he served for 12 years as faculty and attending surgeon. His career then included time at the Beth Israel Deaconess Medical Center in Boston before returning to New Orleans just in time for Hurricane Katrina. Dr. Opelka is a board certified colon and rectal surgery. He is a fellow of the American College of Surgeons and the American Society of Colon and Rectal Surgeons.

American Hospital Association
Rhonda Anderson, RN, DNSc, FAAN

Rhonda Anderson, RN, DNSC, FAAN, is Chief Executive Officer of Cardon Children's Medical Center in Mesa, Arizona. She is a Fellow in the American Academy of Nursing and the American College of Healthcare Executives. She also serves on the Institute for Interactive Patient Care (GetWell Network) National Advisory Board, National Guideline Clearinghouse and National Quality Measures Clearinghouse Expert Panel, American Hospital Association Board of Trustees, American Hospital Association Health Research and Educational Trust Board, and a member of the National Association of Children's Hospitals and Related Institutions Quality Council. Rhonda received the Distinguished Achievement Award from Arizona State University College of Nursing and was a selected participant in The First International Institute: Executive Nurse Leadership in the United Kingdom and the United States-Florence Nightingale Trust in London, England. She attended the Wharton School of Business as a selected participant in The Johnson & Johnson Fellowship Program. In November 2005, Rhonda was awarded the Nursing Legends Nurse of the Year Award by the March of Dimes. Rhonda was awarded the American Organization of Nurse Executive's Lifetime Achievement Award in April of 2006, NurseWeek's Lifetime Achievement Award in September of 2006, and is a Phoenix Business Journal 2011 Women in Business Honoree.

American Medical Association
Carl A. Sirio, MD

Carl A. Sirio, MD, a board certified internist and critical care physician, was elected to the American Medical Association (AMA) Board of Trustees (BOT) in June 2010. Prior to his election, Dr. Sirio served in the AMA House of Delegates as a delegate from Pennsylvania. Dr. Sirio has a long history of service to the profession. He served eight years on the AMA Council on Medical Education, including serving as chair. He helped establish and chaired the AMA Initiative to Transform Medical Education since inception. In addition, he also represented the AMA to the Liaison Committee on Medical Education where he was in part responsible for the new standards related to building greater diversity in medicine and to understanding the impact the learning environment has on students as they prepare for careers as physicians. Prior to this he served on the Internal Medicine Residency Review Committee, responsible for policy and accreditation of all graduate medical education programs in internal medicine. Dr. Sirio has broad interests that include the organization and delivery of health care services, medical education,

patient safety, quality of care, patient risk assessment, evaluation of clinical performance, process improvement, and health care management and financing. Capitalizing on these interests he serves on the Executive Committee of the Physician Consortium for Performance Improvement, helping to drive the development of evidenced based measures for use by doctors in their efforts to improve care. Dr. Sirio is a co-founder of the Pittsburgh Regional Healthcare Initiative (PRHI), a nationally recognized multistakeholder collaborative designed to improve care over a large geographic area. With PRHI he facilitated the work of 40 competing institutions in an effort to improve care for all patients by reducing infections and improving medication safety. He was the recipient of several large grants from the Agency for Healthcare Research and Quality, equaling more than $6.5 million in total, for work designed to foster meaningful improvement in the care of patients. In addition, he has worked with the National Quality Forum, the National Institute of Medicine, The Joint Commission, and the U.S. Pharmacopoeia, among others, in his efforts related to patient care quality and safety. After spending 17 years at the University of Pittsburgh School Medicine where he was a professor, Dr. Sirio recently moved to the Pittsburgh campus of the Drexel University School Medicine. Completing his undergraduate and medical school training at Columbia University and Rutgers Medical School (now Robert Wood Johnson School of Medicine), Dr. Sirio received post graduate medical training at the Milton S. Hershey Medical Center – Pennsylvania State University, the National Institutes of Health and George Washington University. Dr. Sirio is married to Mary Beth Sirio, RN, MBA, and has four children—Alex, Nicholas, James and Alessandra ranging in age from infancy to 19 years.

American Medical Group Association
Sam Lin, MD, PhD, MBA, MPA, MS

Samuel Lin received his MD and PhD from the Oregon Health Sciences University and is a member of the Alpha Omega Alpha Medical Honor Society. His other degrees include a BS (Seattle Pacific University), MS (Oregon State), MPA (Troy State University) and MBA (Johns Hopkins University). He began his professional career as a US Public Health Service (PHS) Commissioned Officer in the US Department of Health and Human Services (DHHS) and received exceptional capability promotions to the ranks of Captain and to Rear Admiral. From his first assignment as a General Medical Officer and Clinical Director in the US Indian Health Service (IHS), he next headed the IHS Physician Branch. Later, he headed the Office for Europe, DHHS Office of International Health and served as the US Executive Secretary for Joint US Health Commissions with the former USSR, Poland and former Yugoslavia. He was appointed DHHS Deputy Assistant Secretary for Health from 1981 to 1992. During this time, he also served as Acting Director of the National Center for Health Services Research (now Agency for Healthcare Research and Quality), as Acting Director of the Office of Minority Health and as Chair of the Special Committee to Investigate the FDA's Center for Veterinary Medicine. He also served on various policy committees of DHHS UnderSecretaries and FDA Commissioners and as an ex-officio member of a number of NIH Advisory Councils. From 1992 until 1994, he served as Acting DHHS Deputy Assistant Secretary for Minority Health and then as Senior Advisor to the DHHS Deputy Assistant Secretary for International Health focusing on Asian-Pacific Rim and US-Mexico Border health issues. While in Federal service, he co-founded several organizations (the Asian Pacific Islanders American Health Forum, the Association of Asian Pacific Community Health Organizations and the Asian Pacific Nurses Association). He has served, or currently serves, on Boards of VetsFirst, United Spinal Association, Daiichi Sankyo, Inc., Military Officers Association of America, National Capital Area Epilepsy Foundation, China Foundation, Inc., Hepatitis Foundation International, Rock-Asia Capital Group, Ltd., Omega Systems Group, Inc., National Military Family Association, as Commissioner and Vice Chair of the Maryland Health Services Cost Review Commission and as Commissioner and Chair of the Maryland Community Health Resources Commission. He serves as the American Medical Group Association's Alternate Delegate to the American Medical Association (AMA). He has been recognized with the Veterans of Foreign Wars' Commander-in-Chief Gold Medal of Merit, institution of the US Public Health Service Samuel Lin Award, Seattle Pacific University's 2008 Alumnus of Year, AMA Foundation's 2008

Excellence in Medicine Leadership Award, Oregon Health & Sciences University 2009 Alumni Award for Medical Leadership. After leaving Federal service, he joined the then-Upjohn Company as Executive Director for Federal Medical Affairs. He established new business relationships and marketing opportunities in diverse arenas including the healthcare of military beneficiaries. He subsequently established The Lin Group, LLC and then Humetrics, Inc., a service disabled, veteran owned small business, and serves as a proprietary consultant or project director for domestic and global healthcare ventures in areas such as health care management and administration, biomedical research and development, biomedical technology and transfer, pharmaceutical and device approvals, health information technology, health management and administration, health facility financing and construction, health systems-medical home and accountable care organizations, alternative and complementary medicine and applied technologies in counter-bioterrorism and homeland security.

American Nurses Association
Marla J. Weston, PhD, RN
Marla J. Weston, PhD, RN, a nurse leader with nearly 30 years of diverse management experience in health care operations, is the chief executive officer (CEO) of the American Nurses Association (ANA), and the American Nurses Foundation (ANF). Dr. Weston currently is involved in multiple performance measurement and public reporting initiatives. She is ANA's representative to the National Priorities Partnership, Hospital Quality Alliance, and Nursing Alliance for Quality Care. Prior to assuming the leadership post at ANA, Dr. Weston developed and managed U.S. Department of Veterans Affairs initiatives to improve the quality of health care for veterans in all Veterans Healthcare Administration facilities nationwide, with a focus on improving the VA nursing workforce. She implemented strategies to improve the work environment, created policies and programs to attract and retain a highly qualified nursing workforce, and promoted nursing as a career choice. Dr. Weston served for four years as the Arizona Nurses Association's executive director, where she led efforts to advocate for nurses on the state and national level and promoted the Magnet Recognition concept, an indication of excellent quality of nursing in hospitals. As a principal in her own consulting firm, Dr. Weston has advised hospitals and educational institutions on quality improvements, as well as resource management, recruitment and retention, and regulatory compliance. Earlier in her career, Dr. Weston worked in a variety of hospital nursing roles for 18 years, including direct patient care in intensive care and medical-surgical units, nurse educator, clinical nurse specialist, director of patient care support and nurse executive. As a hospital administrator, Dr. Weston oversaw structural changes in services that resulted in improved patient satisfaction scores and quality measures. Dr. Weston graduated from Indiana University of Pennsylvania with a bachelor's of science degree in nursing. She graduated from Arizona State University, with a master's of science degree in nursing. She earned her doctoral degree at the University of Arizona. Her dissertation topic, "Antecedents to control over nursing practice," addressed ways to increase the decision-making role of the hospital nurse – in short, nurse influence and power.

Catalyst for Payment Reform
Suzanne F. Delbanco, PhD
Suzanne F. Delbanco is the executive director of Catalyst for Payment Reform (www.catalyzepaymentreform.org). Catalyst for Payment Reform (CPR) is an independent, non-profit organization working on behalf of large employers to catalyze improvements to how we pay for health care in the U.S. to signal powerful expectations for better and higher-value care. In addition to her duties at CPR, Suzanne is on the Advisory Committee to the Director of the Centers for Disease Control and Prevention (CDC). She just joined HFMA's Healthcare Leadership Council and serves on the boards of the Health Care Incentives Improvement Institute, the Anvita Health Advisory Council, the executive committee of the California Maternal Quality Care Collaborative, and participates in the Healthcare Executives Leadership Network. Prior to CPR, Suzanne was President, Health Care Division at Arrowsight, Inc., a company using video to help hospitals measure the performance of health care

workers and provide them with feedback while they are working to improve adherence to safety and quality protocols. From 2000-2007, Suzanne was the founding CEO of The Leapfrog Group. The Leapfrog Group uses the collective leverage of its large corporate and public members to initiate breakthrough improvements in the safety, quality, and affordability of health care for Americans. Before joining Leapfrog, Suzanne was a senior manager at the Pacific Business Group on Health where she worked on the Quality Team. Prior to PBGH, Suzanne worked on reproductive health policy and the changing healthcare marketplace initiative at the Henry J. Kaiser Family Foundation. Suzanne holds a Ph.D. in Public Policy from the Goldman School of Public Policy and a M.P.H. from the School of Public Health at the University of California, Berkeley.

Consumers Union
Steven Findlay, MPH
Steven Findlay is a Senior Health Policy Analyst at Consumers Union, the non-profit publisher of *Consumer Reports* magazine. He tracks, develops policy and advocates on a range of health care issues, with special focus on: health insurance, provider accountability, quality improvement, comparative effectiveness research, and health information technology. Steve also works with CU's Health Ratings Center, which is responsible for rating medical products and health care providers and services. He joined CU in August 2004 and served until 2008 as the Managing Editor of *Consumer Reports Best Buy Drugs*, a multi-million dollar grant-funded project that provided consumers with information comparing drug treatments for over 20 medical conditions. Prior to joining CU, from 2000 to 2004, Steve was Director of Research and Policy at the National Institute for Health Care Management in Washington D.C. In 1998-99, Steve was Senior Policy Analyst at the National Coalition on Health Care (NCHC), also in Washington. His work in both those positions focused on health reform, health insurance coverage, health care cost issues, Medicare, quality of care, and health information technology. Prior to 1998, Steve had a 20-year career as medical and health care journalist and editor. He worked at both trade and mass media publications, including USA TODAY, *U.S. News & World Report* and *Business & Health* magazine. Steve did his undergraduate work at the University of Colorado and has a Masters Degree in Public Health from Johns Hopkins University.

Federation of American Hospitals
Charles N. Kahn III
Charles N. ("Chip") Kahn III is President and CEO of the Federation of American Hospitals (FAH), the national advocacy organization for investor-owned hospitals and health systems. Before coming to the FAH, he was President of the former Health Insurance Association of America and a professional staff person on Capitol Hill specializing in health policy issues. Mr. Kahn holds a Masters of Public Health (M.P.H.) degree from Tulane University School of Public Health and Tropical Medicine, which in 2001 bestowed upon him its prestigious "Champion of Public Health" award. He received a Bachelor of Arts degree from The Johns Hopkins University.

LeadingAge (formerly AAHSA)
Cheryl Phillips, MD, AGSF
Cheryl Phillips, M.D. is Senior VP of Advocacy at LeadingAge (formerly the American Association of Homes and Services for the Aging). Prior to joining LeadingAge, she was Chief Medical Officer of On Lok Lifeways, the parent to the PACE (Program of All-inclusive Care for the Elderly) model that serves nursing home eligible seniors in the greater San Francisco bay area. Dr. Phillips is the past president of the American Geriatrics Society, the national organization for geriatric health care professionals, and the past president of the American Medical Directors Association, an organization for physicians in long-term care. Dr. Phillips has served on multiple national boards and advisory groups for chronic care including the CMS Technical Expert Panel on Quality Indicators in Long-Term Care, the NCQA Geriatric Measurement Advisory Panel, and the CMS Technical Advisory Panel for Independence at Home

Demonstration. She has twice provided testimony to the U.S. Senate Special Committee on Aging. In 2005, she was appointed by Governor Schwarzenegger as a governor's delegate to the White House Conference on Aging, and is a Governor's appointee to the California Commission on Aging and the California Olmstead Committee. In 2002, she served as one of 30 fellows for the Primary Health Care Policy Fellowship under Secretary Tommy Thompson, Department of Health and Human Services. Dr. Phillips completed her family practice residency and geriatric fellowship at the University of California, Davis.

Maine Health Management Coalition
Elizabeth Mitchell

National Association of Medicaid Directors
Foster Gesten, MD
Foster Gesten is the Medical Director for the Office of Health Insurance Programs in the New York State Department of Health. Dr. Gesten provides clinical direction and leadership for a team of professionals engaged in quality oversight, performance measurement and clinical improvement within health plans and public insurance programs in New York. Major initiatives include the development of statewide public reporting systems for commercial, Medicaid, and Child Health managed care programs on quality, access, and satisfaction, medical home demonstrations, and provider based quality measurement and improvement. His interests include population health, health service research, and quality improvement projects directed at prevention services and chronic care. Dr. Gesten is a member of the National CAHPS Benchmarking Database (NCBD) Advisory Group, the Committee on Performance Measurement (CPM) at the National Committee for Quality Assurance (NCQA), and an Expert Panel Member for the Agency for Healthcare Quality (AHRQ) Health Care Innovations Exchange. Dr. Gesten was trained in general internal medicine at Brown University.

National Partnership for Women and Families
Christine A. Bechtel, MA
Christine Bechtel is the Vice President of the National Partnership for Women & Families, a non-profit consumer advocacy organization based in Washington DC. The National Partnership has been the driving force behind some of the country's most important policies and initiatives, including the Family and Medical Leave Act, the Pregnancy Discrimination Act, and the Consumer Partnership for eHealth. As Vice President, Bechtel oversees the day to day operations of the organization, including its work on health care quality, information technology and patient engagement. She also serves on the federal Health IT Policy Committee. Bechtel was previously Vice President of the eHealth Initiative (eHI), where she led the organization's membership, public policy and government relations work. She has a background in health care quality improvement from her work with the American Health Quality Association and Louisiana Health Care Review, now eQHealth Solutions, a Medicare Quality Improvement Organization (QIO). As a Senior Research Advisor at AARP, Bechtel conducted public opinion studies with consumers regarding their views on national political issues. She began her career as a Legislative Associate for United States Senator Barbara A. Mikulski (D-MD), where she focused on legislative issues ranging from women's health and stem cell research to Medicare and Social Security.

Pacific Business Group on Health
William E. Kramer, MBA
Bill Kramer is Executive Director of National Policy for the Pacific Business Group on Health. In this role he leads the organization's policy work at the federal and state level helping to ensure health care reform is implemented in ways that improve health care quality and reduce costs. Kramer also serves as Project Director for the Consumer-Purchaser Disclosure Project, a collaborative led by PBGH and the National Partnership for Women & Families to bring purchasers and consumers together to improve the quality and affordability of health care. Bill has a long and distinguished career in health care. Most recently, he led his own consulting practice where he was actively involved in health reform in Oregon. There he provided policy analysis and guidance to the Oregon Business Council and strategic and technical assistance to the state government. At the national level, Kramer worked with a group of organizations, including the Small Business Majority, on the design and implementation of health insurance exchanges. Prior to developing his consulting practice, Bill was a senior executive with Kaiser Permanente for over 20 years--most recently as Chief Financial Officer for Kaiser Permanente's Northwest Region. Bill also served as general manager for Kaiser Permanente's operations in Connecticut; earlier in his career, he managed marketing, human resources, and medical economics functions. Prior to his career at Kaiser, he was Chief of Budget and Program Analysis Services for the Washington State Department of Social and Health Services. Bill has an MBA from Stanford Graduate School of Business and a BA from Harvard.

Individual Subject Matter Expert Members (voting)

Child Health
Richard C. Antonelli, MD, MS
Rich is the Medical Director of Integrated Care and of Strategic Partnerships for Children's Hospital Boston. He is on the faculty of Harvard Medical School in the Department of Pediatrics. Between 1987 and 2005, he was in full time, community-based general pediatrics, founding Nashaway Pediatrics in Sterling, MA. Since 1987, his clinical work has focused on providing comprehensive, family-centered care for all children, youth, and young adults, but especially for those with special health care needs. He is a member of the Project Advisory Committee of the National Center for Medical Home Implementation at the American Academy of Pediatrics. He has published data about the outcome efficacy and cost of care coordination services for children and youth with special health care needs and their families in primary care settings. Rich has also published work defining mechanisms for integration and coordination of care across systems including the development of strategies and interventions to improve collaborative efforts between families, primary care providers, and subspecialists. He has served on the Steering Committee for Care Coordination at the National Quality Forum and as an advisor to the Patient-Centered Medical Home measurement tool work group at the National Committee for Quality Assurance (NCQA). In conjunction with researchers and policy representatives from internal medicine and family medicine, he represented the Academic Pediatrics Association in the national initiative *Establishing a Policy Relevant Research Agenda for the Patient-Centered Medical Home: A Multi-Disciplinary Approach.* He co-authored *Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework,* supported by The Commonwealth Fund. Most recently, he was appointed to the Measure Applications Partnership at the National Quality Forum. He has provided consultation on care coordination and integration methodologies and measures to multiple states, to US federal agencies, and to some international stakeholders. Since care coordination is so central to the effective transformation of the American health care system, Antonelli's work has been used for both adult and pediatric health care delivery systems. He has general pediatrics clinical responsibilities in the Primary Care Clinic setting at Children's Hospital Boston where he teaches

residents, students, and fellows. In fact, he still is the primary care provider for several patients who have been with him since he first completed his residency!

Population Health
Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Bobbie Berkowitz is currently the Dean and Mary O'Neil Mundinger Professor of Nursing at Columbia University School of Nursing and Senior Vice President of the Columbia University Medical Center. She was previously the Alumni Endowed Professor of Nursing and Chair of the Department of Psychosocial and Community Health at the University Of Washington School Of Nursing and Adjunct Professor in the School of Public Health and Community Medicine. In addition, she served as a Consulting Professor with Duke University and the University of California at Davis. Dr. Berkowitz directed the NIH/NINR funded Center for the Advancement of Health Disparities Research and the National Program Office for the RWJF funded Turning Point Initiative. She joined the faculty at the University of Washington after having served as Deputy Secretary for the Washington State Department of Health and Chief of Nursing Services for the Seattle-King County Department of Public Health. Dr. Berkowitz has been a member of the Washington State Board of Health, the Washington Health Care Commission, the board of the American Academy of Nursing, and chaired the Board of Trustees of Group Health Cooperative. She serves on a number of editorial boards, including the Journal of Public Health Management and Practice, American Journal of Public Health, Policy, Politics, and Nursing Practice, and as Associate Editor of Nursing Outlook. Dr. Berkowitz is an elected Fellow in the American Academy of Nursing and elected member of the Institute of Medicine. She holds a Ph.D. in Nursing Science from Case Western Reserve University and Master of Nursing and Bachelor of Science in Nursing from the University of Washington. Her areas of expertise and research include public health systems and health equity.

Disparities
Joseph R. Betancourt, MD, MPH
Dr. Betancourt directs the Disparities Solutions Center, which works with healthcare organizations to improve quality of care, address racial and ethnic disparities, and achieve equity. He is Director of Multicultural Education for Massachusetts General Hospital (MGH), and an expert in cross-cultural care and communication. Dr. Betancourt served on several Institute of Medicine committees, including those that produced *Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care* and *Guidance for a National Health Care Disparities Report*. He has also advised federal, state and local government, foundations, health plans, hospitals, health centers, professional societies, trade organizations, pharma, and private industry on strategies to improve quality of care and eliminate disparities. He has received grants from foundations and the federal government, and published extensively in these areas. He is a practicing internist, co-chairs the MGH Committee on Racial and Ethnic Disparities, and sits on the Boston Board of Health as well as Health Equity Committee, and the Massachusetts Disparities Council.

Rural Health
Ira Moscovice, PhD
Dr. Moscovice is the Mayo Professor and Head of the Division of Health Policy and Management at the University of Minnesota School of Public Health. He is director of the Upper Midwest Rural Health Research Center funded by the Federal Office of Rural Health Policy (ORHP). He has written extensively on issues related to rural health care and use of health services research to improve health policy decision making in state government. Dr. Moscovice is one of the leading rural health services researchers in the nation and was the first recipient of the National Rural Health Association's Distinguished Researcher Award in 1992. In 2002, he received a Robert Wood Johnson Foundation Investigator Award in Health Policy Research and in 2004 he served as a member of the Future of Rural Health Care Panel of the Institute of Medicine, National Academies. Dr. Moscovice has served as the principal investigator for numerous rural health studies funded by, among others, ORHP, the Centers for

Medicare and Medicaid Studies, AHRQ, the Robert Wood Johnson Foundation, and the U.S. Department of Veterans Affairs. His current research interests include the quality of rural health care, the evaluation of alternative rural health care delivery systems, hospice and end-of-life care for rural Medicare beneficiaries, technology diffusion in rural areas, and the implementation and the assessment of rural health networks.

Mental Health
Harold A. Pincus, MD

Harold Alan Pincus, M.D. is Professor and Vice Chair of the Department of Psychiatry at Columbia University's College of Physicians and Surgeons, Director of Quality and Outcomes Research at New York Presbyterian Hospital and Co-Director of Columbia's Irving Institute for Clinical and Translational Research. Dr. Pincus also serves as a Senior Scientist at the RAND Corporation. Previously he was Director of the RAND-University of Pittsburgh Health Institute and Executive Vice Chairman of the Department of Psychiatry at the University of Pittsburgh. He is the National Director of the Health and Aging Policy Fellows Program (funded by Atlantic Philanthropies), and directed the Robert Wood Johnson Foundation's National Program on Depression in Primary Care and the John A. Hartford Foundation's national program on Building Interdisciplinary Geriatric Research Centers. Dr. Pincus was also the Deputy Medical Director of the American Psychiatric Association and the founding director of APA's Office of Research and Special Assistant to the Director of the NIMH and also served on White House and Congressional staffs. Dr. Pincus was Vice Chair of the Task Force on Diagnostic and Statistical Manual, Fourth Edition (DSM IV) and has been appointed to the editorial boards of ten major scientific journals. He has edited or co-authored 23 books and over 300 scientific publications on health services research, science policy, research career development and the diagnosis and treatment of mental disorders. Among other projects, he is currently leading the national evaluation of mental health services for veterans and the redesign of primary care/ behavioral health relationships in New Orleans. He has also been a consultant to federal agencies and private organizations, including the U.S. Secret Service, Institute of Medicine, John T. and Catherine D. MacArthur Foundation and served on multiple national and international committees. He is a member of the Scientific Council of the National Alliance for the Mentally Ill and chairs the NIH/NCRR Evaluation Key Function Committee for Clinical and Translational Science Awards and the WHO/ICD 11 Technical Advisory Group on Quality and Patient Safety. For over 22 years he worked one night a week treating the severely mentally ill at a community clinic.

Post-Acute Care/ Home Health/ Hospice
Carol Raphael, MPA

Carol Raphael, MPA, is President and Chief Executive Officer of Visiting Nurse Service of New York, the largest nonprofit home health agency in the United States. She oversees VNSNY's comprehensive programs in post-acute care, long-term care, hospice and palliative care, rehabilitation and mental health as well as its health plans for dually eligible Medicare and Medicaid beneficiaries. Ms. Raphael developed the Center for Home Care Policy and Research, which conducts policy-relevant research focusing on the management and quality of home and community-based services. Previously, Ms. Raphael held positions as Director of Operations Management at Mt. Sinai Medical Center and Executive Deputy Commissioner of the Human Resources Administration in charge of the Medicaid and Public Assistance programs in New York City. Between 1999 and 2005, Ms. Raphael was a member of MedPAC. She served on the New York State Hospital Review and Planning Council for 12 years (1992-2004) and chaired its Fiscal Policy Committee. She chairs the New York eHealth Collaborative and was a member of the IOM's Committee to Study the Future Health Care Workforce for Older Americans, which issued its report in April 2008. She is on the Boards of AARP, Pace University, and the Continuing Care Leadership Coalition. She is a member of the Harvard School of Public Health's Health Policy Management Executive Council, the Markle Foundation Connecting for Health Steering Group, Atlantic

Philanthropies Geriatrics Practice Scholars Program, the Henry Schein Company Medical Advisory Board, the Jonas Center for Excellence in Nursing Advisory Board, NYU College of Nursing Advisory Board, and the New York City Health and Mental Hygiene Advisory Council. She was a member of the Lifetime Excellus Board from 2002-2010. She has authored papers and presentations on post-acute, long-term and end-of-life care and co-edited the book *Home Based Care for a New Century*. Ms. Raphael has an M.P.A. from Harvard University's Kennedy School of Government, and was a Visiting Fellow at the Kings Fund in the United Kingdom. Ms. Raphael was recently listed in *Cram's New York Business* 50 Most Powerful Women in New York City.

Federal Government Members (non-voting, ex officio)

Agency for Healthcare Research and Quality (AHRQ)
Nancy J. Wilson, MD, MPH

Nancy J. Wilson, MD, MPH is Senior Advisor to the Director of the Agency for Healthcare Research and Quality and leads the Agency's work to develop and implement a national strategy for quality improvement that improves the healthcare delivery system, patient health outcomes, and population health. She also supports the newly established federal-wide Working Group to address healthcare quality. She provides strategic leadership and technical assistance on improvement implementation and data sharing among state Medicaid Medical Directors and is currently working with CMS to identify a core set of quality measures for Medicaid eligible adults. Dr. Wilson has a bachelor's degree in nursing from the University of Pittsburgh, a medical degree from Johns Hopkins, and a master's degree in public health/health care management from the Harvard School of Public Health where she completed a health services research fellowship.

Centers for Disease Control and Prevention (CDC)
Chesley Richards, MD, MPH

Chesley Richards MD, MPH, FACP, is the Director, in the Office of Prevention through Healthcare (OPTH) in the Office of the Director, Centers for Disease Control and Prevention. OPTH, a new office at CDC, works to build and enhance strategic collaboration between public health and healthcare sector stakeholders to improve the use of preventive services, and to enhance the quality and safety of healthcare. Previously, Dr. Richards served as the Deputy Director, Division of Healthcare Quality Promotion in the National Center for Infectious Diseases at CDC. Dr. Richards is a board-certified internist and geriatrician and holds an appointment as Clinical Associate Professor of Medicine in the Division of Geriatric Medicine and Gerontology at Emory University. Dr. Richards earned his MD from the Medical University of South Carolina, an MPH in Health Policy and Administration from University of North Carolina at Chapel Hill and is a graduate of the Epidemic Intelligence Service (EIS) at CDC and the Program on Clinical Effectiveness at Harvard School of Public Health. Dr. Richards's interests include patient safety, healthcare quality, and preventive services, especially among older adults.

Centers for Medicare & Medicaid Services (CMS)
Karen Milgate, MPP

Karen Milgate is the Deputy Director of the Center for Strategic Planning in the Centers for Medicare and Medicaid Services (CMS). Since 2006 she has directed cross-agency efforts on key strategic and policy issues. This Center is responsible for providing the agency with in-depth analytic capacity to bring strategic insight to the Administrator and other senior leaders in CMS and HHS. It performs short- and long-term analysis on high profile issues on a quick turnaround basis, and supports the agency in implementing and developing policies on a wide variety of issues related to Medicare and Medicaid. One of the most important issues upon which the Center focuses is the drivers of cost and quality in the Medicare and Medicaid programs. With 20 years of health policy experience, Ms. Milgate previously

held the position of the Director of the Office of Policy in CMS and a Research Director at the Medicare Payment Advisory Commission (MedPAC). At MedPAC she led efforts to analyze strategies for improving and measuring quality for Medicare beneficiaries, including analysis of pay for performance strategies, information technology, and care coordination. She was instrumental in developing MedPAC's ability to measure the quality of inpatient and ambulatory care. Prior to her work at MedPAC she served as the Deputy Executive Vice President for the American Health Quality Association (AHQA). She led their regulatory and legislative efforts to ensure that the skills and knowledge residing in the national network of peer review/quality improvement organizations (PROs) were well utilized by HCFA and Congress. From 1994-2000 she was responsible for the American Hospital Association's policy on such topics as hospital quality and safety measures, privacy, conditions of participation, managed care regulation, EMTALA, mental health parity, and organ donation. As a Senior Associate Director she helped the AHA develop a framework for accountability for quality and represented the AHA as a Board member of the Utilization Review Accreditation Commission and at the National Association of Insurance Commissioners meetings when they developed model health plan standards. She also represented the AHA and AHQA at the National Quality Forum. Ms. Milgate began her health policy career working from the consumer perspective both as a Senior Research Associate at the Washington Business Group on Health working on large Fortune 500 employer issues and as a Health Policy Analyst for the consumer advocacy organization Families USA. Ms. Milgate has a Masters degree in Public Policy from the University of Maryland and undergraduate degrees in Economics and International Studies from the American University.

Health Resources and Services Administration (HRSA)
Victor Freeman, MD, MPP

Victor Freeman MD, MPP, is the Quality Team Lead in the Office for Health Information Technology & Quality [in the Health Resources & Services Administration (HRSA) of the US Department of Health & Human Services]. Dr. Freeman brings a diverse background to his federal service. His health care quality improvement experience began with work in public hospitals. He served as lead physician for a management consulting team that did emergency department workflow-redesign and ambulatory clinic scheduling redesign for Grady Hospital, in Atlanta. Appointed by the DC Mayor for board trustee service at DC General Hospital, Dr. Freeman also had board oversight for clinical care and pharmaceutical utilization, as well as for hospital accreditation. As the Medical Director for Quality for a multi-hospital health system in northern Virginia, he led clinical process re-design projects as well as medication safety and pharmaceutical utilization initiatives. Among his physician peers, he has enjoyed leadership roles ranging from being president of the Medical Society of the District of Columbia (MSDC) to having an appointment to the AMA House of Delegates and the AMA's Council on Long Range Planning. After 9-11, he devoted himself to becoming a community disaster preparedness trainer and the Volunteer Chair for Disaster Health Services for the Red Cross of the National Capital Area. He has been a strong community health advocate and has been appointed to a number of public health committees by the mayor and city council of Washington DC. In 2000, Dr. Freeman received the MSDC "Dr. Charles Epps III – Community Service" Award for his work on behalf of the "health care safety net" in the nation's capital. After earning a BA in Psychology from Harvard University, Dr. Freeman became a Harvard International Fellow, studying health care systems in Europe. He earned his MD from Stanford University Medical School and did his (Primary Care) Internal Medicine residency at Massachusetts General Hospital. He has a Master's in Public Policy from Georgetown University, where he did his Primary Care Research (Ethics) Fellowship in the university's Clinical Economic Research Unit.

Office of Personnel Management/FEHBP (OPM)
John O'Brien
John O'Brien is the Director of Health Care and Insurance at the Office of Personnel Management. In this position he oversees the insurance programs for federal employees including the Federal Employees Health Benefit (FEHB) program, which provides health insurance to over 8 million federal employees, retirees, and their dependents. In addition, he leads the team implementing OPM's responsibilities under the Affordable Care Act (ACA) including the development of multi-state plans for state exchanges. From 2007 to 2009 he helped oversee the State of Maryland's unique all-payer hospital rate setting system as the Deputy Director for Research and Methodology at the Maryland Health Services Cost Review Commission (HSCRC). From 1997 to 2007 he was the Director of Acute Care Policy at the University of Maryland, Baltimore County (UMBC) Hilltop Institute where his work focused on the management and oversight of Medicaid managed care plans. Mr. O'Brien was a 2005 recipient of an Ian Axford Fellowship in Public Policy under which he studied health system performance measurement in New Zealand. He has a Master Degree in Public Administration from Syracuse University.

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

Accreditation/Certification Liaisons (non-voting)

American Board of Medical Specialties
Christine Cassel, MD
Dr. Cassel, a leading expert in geriatric medicine, medical ethics and quality of care, is President and CEO of the American Board of Internal Medicine and the ABIM Foundation. She is board certified in internal medicine and geriatric medicine. Dr. Cassel is past President of the American Federation for Aging Research and the American College of Physicians. She also formerly served as Dean of the School of Medicine and Vice President for Medical Affairs at Oregon Health and Science University, Chair of the Department of Geriatrics and Adult Development at Mount Sinai School of Medicine and Chief of General Internal Medicine at the University of Chicago. Dr. Cassel is one of 20 scientists chosen by United States President Barack Obama to serve on the President's Council of Advisors on Science and Technology (PCAST) and is co-Chair and physician leader of a PCAST report to the President on future directions of health information technology. A member of the Institute of Medicine (IOM) since 1992, she served on the IOM's Comparative Effective Research (CER) Committee and the IOM committees that wrote the influential reports "To Err is Human" and "Crossing the Quality Chasm." She chaired major IOM reports on public heath (2002) and on palliative care (1997). In 2009 and 2010, Modern Healthcare named Dr. Cassel among the 50 most powerful physicians and ranked among the top 100 most powerful people in health care. An active scholar and lecturer, she is the author or co-author of 14 books and more than 200 journal articles on geriatric medicine, aging, bioethics and health policy. A graduate of the University of Chicago, Dr. Cassel received her medical degree from the University of Massachusetts Medical School. She is the recipient of numerous honorary degrees and awards of distinction, including honorary Fellowship in the Royal College of Medicine of England and the Royal College of Physicians and Surgeons of Canada, and Mastership in the American College of Physicians.

National Committee for Quality Assurance
Margaret E. O'Kane, MPH
Since 1990, Margaret E. O'Kane has served as President of the National Committee for Quality Assurance (NCQA), an independent, non-profit organization whose mission is to improve the quality of health care everywhere. Under her leadership, NCQA has developed broad support among the consumer, employer and health plan communities. About three-quarters of the nation's largest employers evaluate

plans that serve their employees using Healthcare Effectiveness Data and Information Set (HEDIS®) data. In recent years, NCQA has received awards from the National Coalition for Cancer Survivorship, the American Diabetes Association and the American Pharmacists' Association. In addition to her leadership of NCQA, Ms. O'Kane plays a key role in many efforts to improve health care quality. Recently, she was awarded the 2009 Picker Institute Individual Award for Excellence in the Advancement of Patient-Centered Care for her leadership of NCQA and lifetime achievement in improving patient-centered health care. In 1999, Ms. O'Kane was elected as a member of the Institute of Medicine. She also serves as co-chair of the National Priorities Partnership, a broad-based group of high-impact stakeholder organizations, working together to bring transformative improvement to our health care system. Ms. O'Kane began her career in health care as a respiratory therapist and went on to earn a master's degree in health administration and planning from the Johns Hopkins University.

The Joint Commission
Mark R. Chassin, MD, FACP, MPP, MPH
Mark R. Chassin, M.D., FACP, M.P.P., M.P.H., is president of The Joint Commission. In this role, he oversees the activities of the nation's leading accrediting body in health care. Joint Commission accreditation and certification is recognized worldwide as a symbol of quality that reflects an organization's commitment to quality improvement and to meeting state-of-the-art performance standards. Dr. Chassin is also president of the Joint Commission Center for Transforming Healthcare. Established in 2009 under Dr. Chassin's leadership, the Center works with the nation's leading hospitals and health systems to address health care's most critical safety and quality problems such as health care-associated infection (HAI), hand-off communications, wrong site surgery, surgical site infections, and preventing avoidable heart failure hospitalizations. The Center is developing solutions through the application of the same Robust Process Improvement™ (RPI) methods and tools that other industries rely on to improve quality, safety and efficiency. In keeping with its objective to transform health care into a high reliability industry, The Joint Commission shares these proven effective solutions with the more than 19,000 health care organizations it accredits and certifies. Previously, Dr. Chassin was the Guggenheim Professor of Health Policy; founding Chairman of the Department of Health Policy at the Mount Sinai School of Medicine, New York; and Executive Vice President for Excellence in Patient Care at The Mount Sinai Medical Center. Dr. Chassin also served as Commissioner of the New York State Department of Health. He is a board-certified internist and practiced emergency medicine for 12 years, and is a member of the Institute of Medicine of the National Academy of Sciences. Dr. Chassin received his undergraduate and medical degrees from Harvard University. He holds a master's degree in public policy from Kennedy School of Government at Harvard, and a master's degree in public health from UCLA.

National Quality Forum Staff

Janet M. Corrigan, PhD, MBA
Janet M. Corrigan, PhD, MBA, is president and CEO of the National Quality Forum (NQF), a private, not-for-profit standard-setting organization established in 1999. The NQF mission includes: building consensus on national priorities and goals for performance improvement and working in partnership to achieve them; endorsing national consensus standards for measuring and publicly reporting on performance; and promoting the attainment of national goals through education and outreach programs. From 1998 to 2005, Dr. Corrigan was senior board director at the Institute of Medicine (IOM). She provided leadership for IOM's Quality Chasm Series, which produced 10 reports during her tenure, including: To Err is Human: Building a Safer Health System, and Crossing the Quality Chasm: A New Health System for the 21st Century. Before joining IOM, Dr. Corrigan was executive director of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Among Dr. Corrigan's numerous awards are: IOM Cecil Award for Distinguished Service (2002), American College of Medical Informatics Fellow (2006), American College of Medical Quality Founders' Award (2007), Health Research and Educational TRUST Award (2007), and American Society of Health System Pharmacists' Award of Honor (2008). Dr. Corrigan serves on various boards and committees, including: Quality Alliance Steering Committee (2006–present), Hospital Quality Alliance (2006–present), the National eHealth Collaborative (NeHC) Board of Directors (2008–present), the eHealth Initiative Board of Directors (2010–present), the Robert Wood Johnson Foundation's Aligning Forces for Healthcare Quality (AF4Q) National Advisory Committee (2007–present), the Health Information Technology (HIT) Standards Committee of the U.S. Department of Health and Human Services (2009–present), the Informed Patient Institute (2009 – present), and the Center for Healthcare Effectiveness Advisory Board (2011 – present). Dr. Corrigan received her doctorate in health services research and master of industrial engineering degrees from the University of Michigan, and master's degrees in business administration and community health from the University of Rochester.

Thomas B. Valuck, MD, JD, MHSA

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

Nalini Pande, JD

Nalini Pande, JD, is a Senior Director with fifteen years of experience in quality of care, Medicare, Medicaid, physician, health plan and hospital issues. She is currently supporting the work of the NQF Measure Applications Partnership and was previously leading NQF's Measure Development & Endorsement Agenda project, working with the Measure Prioritization Advisory Committee. She has significant expertise in value-based purchasing, public reporting and payment reform. She has also worked with numerous clients on federal and state healthcare regulatory compliance. She has provided policy assistance to health care entities with regard to Medicare and Medicaid and the regulatory prescriptive elements of the Medicare Prescription Drug Act. Prior to joining NQF, Ms. Pande worked as a health policy consultant at The Lewin Group and a health policy attorney at Foley & Lardner and Crowell & Moring. She has represented clients before numerous government agencies including CMS and state Medicaid agencies. At Lewin, Ms. Pande led a two-year project assisting the Mayor of San Francisco in implementing universal coverage, including implementing medical homes and addressing quality of care issues. She also worked with numerous Insurance Commissioners on individual and small

group market rate regulation and led several projects on value-based purchasing and pay-for-performance programs. Ms. Pande worked as a Program Officer at the California HealthCare Foundation and served as pro bono counsel to the Washington, D.C. Primary Care Association. As pro bono counsel, Ms. Pande worked on the Healthy Communities Access Program, Medical Homes DC Project in which she assisted DCPCA in strengthening, coordinating and integrating a broad range of primary care health services in the community health system serving the uninsured and underinsured residents of DC. Ms. Pande is a graduate of Harvard Law School and Princeton University (A.B., Woodrow Wilson School of Public Policy and International Affairs). She is a member of the DC Bar, Maryland Bar, American Health Lawyers Association and American Bar Association. She has also served as the Chair of the DC Bar Health Law Steering Committee.

Allison Ludwig, RN, MPH, MHA

Allison Ludwig is a Project Manager, Strategic Partnerships, at the National Quality Forum, a nonprofit membership organization with the mission to build consensus on national priorities and goals for performance improvement and endorse national consensus standards for measuring and publicly reporting on performance. Ms. Ludwig supports the work of the NQF-convened Measures Application Partnership Coordinating Committee. Prior to joining NQF, Ms. Ludwig spent two years as an Administrative Fellow at the University of Pittsburgh Medical Center where she worked in various capacities, primarily working to support quality initiatives and further build quality infrastructure at the UPMC Cancer Centers. Before joining UPMC, Ms. Ludwig began her career as a surgical oncology staff nurse at the University of Minnesota Medical Center - Fairview in Minneapolis, MN. Ms. Ludwig received her Bachelor of Science in Nursing from the University of Wisconsin, a Master of Public Health - Health Policy and Master of Health Administration from the University of Iowa.

Amaru J. Sanchez, MPH

Amaru J. Sanchez, MPH, is a Project Analyst at the National Quality Forum (NQF), a private, nonprofit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Mr. Sanchez is currently supporting the work of the NQF Measure Applications Partnership, established to provide multi-stakeholder input to the Department of Health and Human Services on the selection of performance measures for public reporting and payment reform programs. Prior to joining NQF, Mr. Sanchez served as a Health Policy Research Analyst for the bicameral Public Health Committee at the Massachusetts Legislature. At the legislature, Mr. Sanchez influenced the passage of several novel public health and healthcare related laws as well as drafted legislative proposals relative to medical debt, chronic disease management, health disparities and health care transparency. Mr. Sanchez is a graduate of the Boston University School of Public Health (MPH, Social Behavioral Sciences/Health Policy and Management) and the University of Florida (BS, Integrative Biology).

May 3-4 In-Person Meeting Summary

Tab 10

MEASURE APPLICATIONS PARTNERSHIP
COORDINATING COMMITTEE
Convened by the National Quality Forum

Summary of In-Person Meeting #1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Further, the Coordinating Committee proposed the following:

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

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

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

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

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

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

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

Coordinating Committee Member Terms, Beginning May 2011

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

May 13, 2011 Web Meeting Summary

Tab 11

MEASURE APPLICATIONS PARTNERSHIP
Workgroup Orientation
Convened by the National Quality Forum

Summary of MAP Workgroup Orientation Web Meeting

A web meeting of the Measure Applications Partnership (MAP) Coordinating Committee and workgroups (Ad Hoc Safety Workgroup, Clinician Workgroup, Dual Eligible Beneficiaries Workgroup, Hospital Workgroup, and Post-Acute Care/Long-Term Care Workgroup), was held on Friday, May 13, 2011. For those interested in viewing an online archive of the web meeting please visit the link below:

http://www.myeventpartner.com/WebConference/RecordingDefault.aspx?c_psrid=E951DF80834B

The next meetings for the MAP Coordinating Committee and workgroups will take place as follows:

Committee/Workgroup	Date
Dual-Eligible Beneficiaries Workgroup In-Person Meeting #1	June 2-3, 2011
Clinician Workgroup In-Person Meeting #1	June 7-8, 2011
Ad Hoc Safety Workgroup In-Person #1	June 9-10, 2011
Coordinating Committee In-Person Meeting #2	June 21-22, 2011
Hospital Workgroup In-Person Meeting #1	October 12-13, 2011

Committee Members in Attendance at the May 13, 2011 Web Meeting:
Please see attachment for a listing of members in attendance.

The primary objectives of the web meeting were to:
- Set context for the role of the MAP;
- Review Coordinating Committee and workgroup charges;
- Describe initial tasks of the MAP.

George Isham, Coordinating Committee Co-Chair; Chip Kahn, President, Federation of American Hospitals; and Tom Valuck, Senior Vice President, Strategic Partnerships, NQF, provided the context for the role of the MAP. They stated the need for a formal process for public and private sector collaboration to select the best measures for specific public reporting and performance-based payment programs. Mr. Kahn provided the historical perspective, stating that the multi-stakeholder group, Stand for Quality, was the impetus for the creation of the MAP. Tom Valuck discussed the relationships among the roles of the National Priorities Partnership, a multi-stakeholder group that provides input to the HHS National Quality Strategy; the role of measure endorsement, which endorses measures for public reporting and quality improvement; and the role of the MAP in selecting measures for particular purposes, such as public reporting and payment reform. The MAP will look to the portfolio of endorsed measures and those that could be brought into the portfolio of endorsed measures in an expedited

manner. The MAP will then be able to identify gaps in quality measures, including measure gaps, endorsement gaps and data gaps.

Tom Valuck provided an overview of the statutory authority, function, and structure of the MAP. The Coordinating Committee, comprised of multi-stakeholder members, is charged with providing input to HHS on the selection of performance measures for use in public reporting, performance-based payment, and other programs; advising HHS on the coordination of performance measurement strategies across public sector programs, across settings of care, and across public and private payers; setting the strategy for the two-tiered Partnership; and giving direction to and ensuring alignment among the MAP advisory Workgroups. Also discussed was the decision-making framework that will be utilized as input into the MAP work. These strategies and models include the HHS National Quality Strategy (NQS), HHS Partnership for Patients safety initiative, the high impact conditions as identified by the NQF-convened Measure Prioritization Advisory Committee, and the NQF endorsed Patient-focused Episodes of Care Model. Additional factors for consideration were added at the first Coordinating Committee meeting to include the HHS Multiple Chronic Conditions Framework, attention to equity across the NQS priorities, and the importance of considering the connection to financing and delivery models and the broader context (e.g., ACOs).

Dr. Patrick Romano, Professor of General Medicine and Pediatrics, University of California, discussed the development of decision making criteria for recommending measures for public reporting, payment programs, and program evaluation. A key aspect of this work will be to ensure that the measure selection criteria will build on, and not duplicate, the NQF measure endorsement criteria. The first step in the process was to inventory and compare historical criteria sets to prepare a comprehensive criteria set. Future steps include stress tests, evaluation of findings with key informants, and the final recommendation of a set of criteria for consideration by the MAP Coordinating Committee for payment, public reporting, and program development.

Nalini Pande, Senior Director, Strategic Partnerships, NQF, provided an overview of the approach for the project, describing the tasks specified by HHS. Additionally, Ms. Pande presented the Coordinating Committee and workgroup rosters, comprised of multi-stakeholders, along with the charges for the Coordinating Committee and each workgroup.

The next meeting of the combined MAP Coordinating Committee and workgroups will be via web on December 8, 2011.

Committee and Workgroup Members in Attendance:

Coordinating Committee:
(attendance was optional)

George Isham, Committee Co-Chair
Elizabeth Mitchell, Maine Health Management Coalition
Foster Gesten, NAMD
Frank Opelka, ACS
Harold Pincus
Maureen Dailey, substitute, ANA
Rhonda Anderson, AHA

Dual Eligible Beneficiary Workgroup:

Alice Lind, Workgroup Chair
Adam Burrows, National PACE Association
Cheryl Powell, CMS Federal Coordinated Health Care Office
Daniel Kivlahan, VHA
Gail Stuart
Henry Claypool, HHS Office on Disability
Juliana Preston
Laura Linebach, LA Care Health Plan
Lawrence Gottlieb
Leonardo Cuello, National Health Law Program
Mady Chalk
Margaret Nygren, AAIDD
Patricia Nemore, Center for Medicare Advocacy
Patrick Murray, Better Health Greater Cleveland
Rita Vandivort, SAMHSA
Sally Tyler, AFSCME
Samatha Wallack, HRSA
Steve Counsell, NAPH
Tom James, Humana

PAC/LTC Workgroup:

Carol Spence, NHPCO
Charissa Raynor, SEIU
Debra Saliba
Emilie Deady, VNAA
Gerri Lamb
James Lett, NTOCC
Judith Sangl, AHRQ
Lisa Tripp, National Consumer Voice for Quality Long-Term Care
Maryanne Lindeblad
Randall Krakauer, Aetna
Robert Hellrigel, Providence Health and Services
Roger Herr, APTA
Scott Shreve, VHA
Sean Muldoon, Kindred Healthcare
Shari Ling, CMS
Suzanne Snyder, AMRPA
Tom Vonsternberg

Clinician Workgroup:

Amy Compton-Phillips, Kaiser Permanente
Beth Averbeck, MN Community Measurement
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MAP Coordinating Committee In-Person Meeting Day 1 Recap

Tab 12

Measure Applications Partnership Coordinating Committee

In-Person Meeting #2

Recap of Day 1

HIT

- Data sources and HIT will be a part of each coordination strategy
  - Data sources inextricably linked to ability to measure
  - Aspiring to a flexible data platform (e.g. health information exchanges; all-payer data)
- Short-term vs Long-term perspective
  - Leverage claims and registries while working towards e-measures
  - Retool current measures for electronic reporting
- Standardization is important, but each program may have unique needs

Measure Selection Criteria

- Refer to revised strawperson document
- Next steps:
  - July: NQF staff to refine strawperson in collaboration with Stanford team
  - August 5: Web Meeting to discuss final draft
  - August 17-18: In-Person Meeting to adopt Measure Selection Criteria

Coordinating Committee Guidance to Clinician Workgroup

NQF
National Quality Forum

- Scope of Clinician Coordination Strategy
  - Focus on Federal programs
    - Alignment a key consideration
  - Detailed review of private sector programs beyond scope
  - Propose Phase 2 to address public/private alignment, building on alignment across Federal programs

Coordinating Committee Guidance to Clinician Workgroup continued…

- Patient as part of "teamness"
  - Importance of patient reported data
- Considering both quality and cost at the population and clinician levels
  - Both individual clinician and group levels of analysis
- Not getting locked into current limitations regarding flow of information and practice patterns

MAP Measure Selection Criteria: "Strawperson" for Coordinating Committee Reaction

Tab 13

MAP Measure Set Selection Criteria
"Strawperson" for Coordinating Committee Reaction
(Revised End of Day 1 – June 21, 2011)

Measure Sets "Fit for a Specific Purpose"

The MAP Coordinating Committee has been charged with identifying selection criteria to be applied to measure sets for public reporting and payment programs. Collectively, these criteria should address if a measure set under consideration is fit for its intended purpose. The measure set should be inclusive enough to achieve the program goals and be applicable to all entities that have an opportunity to contribute to achieving those objectives.

Inputs to the Strawperson Measure Set Selection Criteria

Several inputs informed the strawperson measure set selection criteria list proposed below. These included:

MAP Coordinating Committee and workgroup deliberations

The MAP Coordinating Committee members weighed in on guiding principles for measure set selection criteria at their first meeting. Subsequent feedback from the Clinician, Dual Eligible Beneficiaries, and Safety Workgroups was instrumental in shaping the strawperson criteria.

NQF measure endorsement criteria

As was agreed at the first MAP Coordinating Committee meeting, the underlying assumption is that the NQF measure endorsement criteria will serve as the baseline. Individual endorsed measures are suitable for a variety of accountability applications, as well as for quality improvement. An NQF-endorsed measure has been determined to address a high impact aspect of healthcare with an opportunity for improvement and sufficient evidence (importance to measure and report); is a reliable and valid indicator of quality (scientific acceptability of measure properties); is understandable and useful for decisions related to accountability and improvement (usable); and is feasible to implement. Therefore, when considering measure set selection criteria, the focus is on sets of measures to achieve specific program goals, rather than on reexamining the integrity of individual measures.

Stanford team

A team assembled by Arnie Milstein, MD, completed a thorough analysis of historical criteria sets, conducted "use cases" across various applications, and reached out to key informants to help elucidate criteria relevant to selecting measures for specific public reporting and payment programs.

Strawperson Measure Set Selection Criteria (Revised End of Day 1 – June 21, 2011)

Based on the inputs above, the following measure set selection criteria have emerged for the Committee's consideration and deliberation:

Measure sets for specific public reporting and payment programs should:

- Align with the priorities in the National Quality Strategy ---safe care; patient and family engagement; effective prevention and treatment; effective communication and care coordination; working with communities to enable healthy living; and affordable care --and consider high impact conditions with the greatest burden and potential gain to patients and the overall population.

- Address health and health care across the lifespan while promoting:
  - seamless care across transitions;
  - systemness;
  - individual and shared accountability among patients, providers, purchasers, health plans, and settings.

- Include measures of total cost of care, efficiency, and appropriateness.

- Be understandable, meaningful, and useful to the intended audiences:
  - Focus on outcome measures and measures with a clear link to improved outcomes
  - Balance issues of feasibility and evidence with users' needs.
  - Have ability to aggregate measures so that they provide meaningful interpretation of results for the given application.

- Core and advanced measure sets should be parsimonious and foster alignment between public and private payers to achieve a multidimensional view of quality.

- Have safeguards in place to detect or mitigate unintended consequences, such as adverse selection, through the use of "balancing measures" or other mechanisms to detect exclusion of high risk patients.

- Address specific program features including target population, setting, level of analysis, transparency and availability of data from various sources.

Individual measures within measure sets for specific public reporting and payment programs should be:

- NQF-endorsed, or if not endorsed, meet conditions for consideration of endorsement (e.g., measures should have been tested).
- Build on measure endorsement thresholds including:
  - Magnitude of the improvability gap;
  - Ability to discriminate to allow for meaningful comparisons; and
  - Proximity to outcomes, including patient-reported outcomes.
- Measures tested for the setting and level of analysis in which it will be implemented.
- Ensure measures have broad applicability across populations and settings.
- Ensure an adequate sample size for stable and meaningful comparison across the intended accountable entities (e.g., ACOs, hospitals, nursing homes, clinicians).