MEASURE APPLICATIONS PARTNERSHIP

Strategic Plan: 2012-2015

PUBLIC COMMENT DRAFT

NATIONAL QUALITY FORUM

National Quality Forum
1030 15th Street, NW
Washington, DC 20005

Table of Contents

Measure Applications Partnership Strategic Plan: 2012-2015

Purpose of the MAP Strategic Plan

The American healthcare system is a complex network of healthcare providers, health professionals, purchasers, health plans, government agencies, and others, working with the public to improve health and healthcare. The opportunity to improve the health of the population, and the quality and cost of healthcare services, represents a tremendous performance gap. Performance measures are important tools to monitor and encourage progress on closing the performance gap. Performance measurement results can also inform decisions by people who are seeking, purchasing, and providing care. To that end, the Measure Applications Partnership (MAP) was convened by the National Quality Forum (NQF) to give input on the best performance measures for public- and private-sector public reporting and performance-based payment programs.

The first year of the Measure Applications Partnership's work yielded a rich experience and highlighted daunting challenges. To build on the experience and place MAP's work squarely in the context of the challenges, the MAP Coordinating Committee resolved to undertake a strategic planning process. Specifically, the following challenges were evident during year-one work:

- **Walls are easier to build up than to break down.** Figuring out how to use measures across programs and sectors, rather than within silos, will be key to a more uniform and integrated measurement approach.
- **Many of the measures needed to support improvement do not exist.** At present, we do not have many of the measures we need to achieve patient-centered measurement across programs.
- **We need to build the infrastructure for our health information "highway" *and* measure "traffic signals."** Effective data collection, transmission, and sharing mechanisms are necessary for a nationally-unified measurement approach.
- **People, not numbers or tools, are the true focus of this work, and not all people's needs are the same.** In particular, we have many vulnerable who live among us, and their situations require specialized and thoughtful approaches to measurement.

To address these challenges and make MAP's work more information-rich, nationally beneficial across public and private sectors, and representative of a true partnership in pursuit of national improvement priorities, MAP has embarked on a three-year strategic planning process.

Background

Problem Statement

More than ten years ago, our nation awakened to a sobering reality: our healthcare system, while delivering innovative help and healing, was also generating preventable harm. People were suffering or dying from avoidable mistakes, and our collective bill was growing for services that often generated little value. All the while, we as a nation were experiencing more life-debilitating disease and watching our overall indicators of health slip.

Various motivated organizations were spurred to take action in pursuit of making healthcare more value-driven. What they had in good intention, they lacked in a coordinated plan. Could various leaders from all corners of healthcare—including those who pay for, deliver, and receive care—join together in articulating a national vision for making healthcare safer and people healthier? Would a prioritized "to-do" list help sharpen healthcare improvement efforts?

Years in the making, we now have a national blueprint for achieving a high-value healthcare system. Called "The National Quality Strategy," it sets clear goals to help the collective public focus its efforts on improving the quality of health and healthcare. Working together on a focused set of activities will accelerate meaningful change.

Performance measurement is an important tool to help incentivize change and monitor progress we're making in achieving the goals articulated in the National Quality Strategy (NQS). Measures give evidence-based signals to healthcare providers and clinicians to further strengthen their performance. Measures also generate valuable information for those who make healthcare decisions, and help everyone with a stake in healthcare better understand the value of what our system produces. Measures make healthcare decision-making information richer, guesswork poorer.

The field of healthcare performance measurement has proliferated in recent years with many in the public and private sectors embracing its promise. However, in trying to realize the potential of using measurement to accelerate efforts to make healthcare safer and more affordable, and make people healthier, the result to date has been a fragmented and siloed patchwork of activity. This mirrors the system in which measures are used, and reinforces that we have great opportunity to be more coordinated in all that we do within healthcare.

Said more plainly, imagine a traffic signaling system that used purple, blue, and beige in certain intersections; red, yellow, green in others; and orange, black, and gold in yet another set of intersections. The likely result would be more car accidents, mass confusion, a lack of clear consumer driving educational tools, and more police resources dedicated to manning those intersections rather than tackling higher crimes. People may start to approach intersections with trepidation rather than confidence. This is where we are in use of measures today.

In an effort to move our country toward a more predictable, uniformly used and understood measurement system—the red, yellow, green signaling for healthcare—the Affordable Care Act calls for a single streamlined process for providing pre-rulemaking input on the selection of measures for various uses. The input is designed to come from all of those who have a stake in the decisions made by the federal government within its healthcare rulemaking process. This represents a sea change in how rules with respect to measurement are shaped.

In past years, The Department of Health and Human Services (HHS) has issued draft rules one healthcare program at a time, inclusive of proposed measures within that program; the market responds via comments; final rules are issued; and measures intended to gauge performance are implemented. This process has not deliberately encouraged a cross-program look at measures in use by the federal government—missing valuable opportunities to create a fully coordinated vision for performance measurement and send strong, unified signals to the healthcare market about incentives and which performance goals to align with. Importantly, the private sector has largely been the recipient of federal rulemaking, with limited ability to provide real world input that could prove beneficial to the optimal shape of rules with respect to selection of measures.

MAP's Role

HHS has contracted with The National Quality Forum (NQF), a mission-driven, neutral, non-profit organization, to convene MAP to be the body that helps coordinate and provide upstream recommendations on measures use. MAP is a unique collaboration of organizations, designed to balance the interests of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. MAP's diverse, public-private nature ensures future federal strategies and rulemaking with respect to measure selection is informed upstream by varied, thoughtful organizations that are invested in the outcomes of measurement decisions made.

In its first year, MAP generated both program-specific measure recommendations to HHS (first annual MAP Pre-Rulemaking Report) and recommendations for coordination of performance measurement across public- and private-sector programs (safety, clinician, post-acute care/long-term care, hospice, cancer hospital, and dual eligible beneficiary coordination strategies). This initial work was a big first step toward achieving a "red, yellow, green" for measurement. It also highlighted that we as a nation have a ways to go.

Recognizing the complexity and importance of MAP's tasks, this strategic plan includes ambitious goals and objectives and deliberate approaches to make progress against the goals and objectives over time. In pursuit of its objectives, MAP has established several overarching strategies to guide its ongoing and future work. MAP has also developed an action plan that delineates concrete tactics for implementing the MAP strategies over the next three years. Initial work on these tactics (e.g., initial development of families of measures) has already and will continue to enhance MAP's input to HHS and the field. As MAP evolves, the tactics will evolve to ensure the MAP strategies are addressed with increasing sophistication.

MAP Goal and Objectives

The National Quality Strategy (NQS) provides the national blueprint for providing better care, improving health for people and communities, and making care more affordable. The NQS identifies priorities and goals for rapidly improving health outcomes and increasing the effectiveness of care for all populations.[1] In pursuit of the aims, priorities, and goals of the NQS, MAP informs the selection of performance measures to achieve the **goal of improvement, transparency, and value for all**.

MAP's objectives are to:

1. **Improve outcomes in high leverage areas for patients and their families.** MAP will encourage the use of the best available measures that are high-impact, relevant, and actionable. Additionally, MAP has adopted a person-centered approach to measure selection, promoting broader use of patient-reported outcomes, experience, and shared-decision making.
2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value.** MAP will promote the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality at all levels of the health care system. Achieving this objective will require filling measure development and implementation gaps.
3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden**. MAP will encourage the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

MAP Strategies

MAP has identified several strategies (bolded below) to achieve its goals and objectives. MAP's primary purpose, as specified in the Affordable Care Act (ACA), is to **provide input on performance measures sets for numerous accountability applications**, such as public reporting, performance-based payment, and financial incentives tied to meaningful use of electronic health records. In its first year, MAP has provided such input through several reports (see clinician, safety, dual-eligible beneficiaries, post-acute care/long-term care coordination strategies for performance

[1] http://www.healthcare.gov/law/resources/reports/nationalqualitystrategy032011.pdf

measurement) and its initial pre-rulemaking input. These reports included recommendations for applying the best available measures and prioritization of measure gaps to guide policymakers' decision-making.

While MAP's input focuses on HHS quality improvement programs, MAP recognizes that aligned performance measurement is important to send clear direction and provide strong incentives to providers and clinicians regarding desired health system change. Accordingly, MAP will **promote alignment of performance measurement across HHS programs and between public and private initiatives**. Strategically aligning public and private payment and public reporting programs (across settings, programs, populations, and payers) will encourage delivery of patient-centered care, reduce providers' data collection burden, and provide a comprehensive picture of quality.

MAP aims to **ensure recommended performance measures are high-impact, relevant, actionable, and drive toward realization of the NQS**. NQF endorsement is a threshold criterion for selecting measures that are important, scientifically acceptable, feasible, and useful for accountability purposes and quality improvement. Through its consensus-driven process, MAP then utilizes its Measure Selection Criteria to recommend measures that are high-impact, align with the NQS, promote alignment across programs, and consider the needs of complex patients. MAP has adopted a person-centered approach to measurement, preferring measures of patient outcomes (or those processes most tightly linked to outcomes) and experience across settings, rather than measures that are specific to providers or settings. Performance measurement is continually evolving and many of the performance measurement programs for which MAP provides input are long established and may include measures that are topped-out, do not drive improvement in patient outcomes, or result in unintended consequences of measurement. Accordingly, MAP will **recommend removal of low-value measures from federal programs.**

MAP's input has and will continue to identify and prioritize measure gaps, recognizing that currently available measures do not fully address the performance gaps that represent the highest-leverage opportunities for improvement. MAP recognizes that it must go beyond stating measure gaps; through collaboration with HHS and private entities, MAP will **stimulate gap-filling for high-priority measure gaps** and **identify solutions to performance measurement implementation barriers**. This includes, but is not limited to, defining measure ideas to address gap areas; identifying needed funding for measure development, testing, and endorsement; engaging measure developers and end-users; facilitating the construction of test beds for measure testing; and identifying opportunities to build mechanisms for efficient collection and reporting of data.

MAP's careful balance of interests is designed to provide HHS and the field with thoughtful input on performance measure selection. As a public-private partnership, MAP must work collaboratively with the stakeholders involved in performance measurement. To facilitate bi-directional exchange with stakeholders, MAP will establish **feedback loops** to (1) **support a data-drive approach to MAP's decision-making and build on other initiatives**, (2) **determine if MAP's recommendations are meeting stakeholder needs and are aligned with their goals**, and (3**) ensure MAP's recommendations are relevant to public and private implementers and its processes are effective.**

Table 1 below demonstrates the relationships among MAP's goals, objectives, strategies, and tactics.

Table 1. MAP Goals, Objectives, Strategies, Tactics

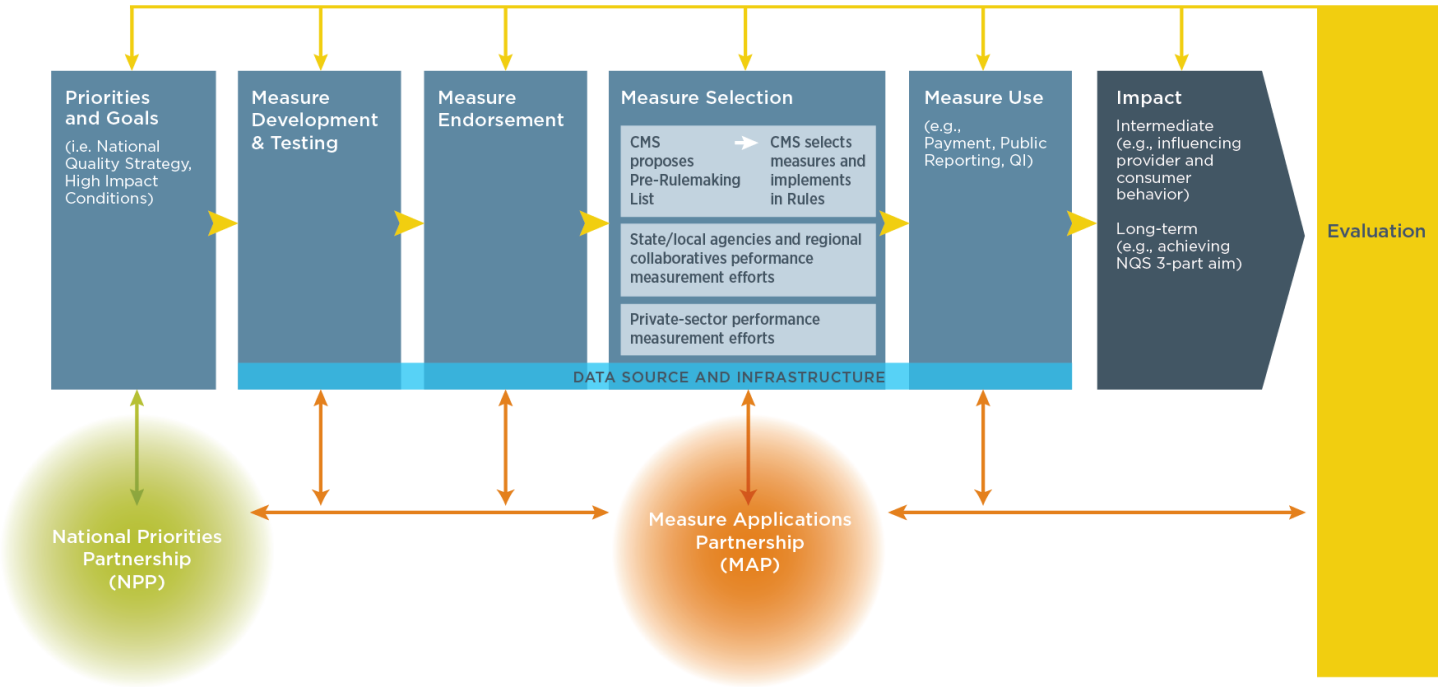
	OBJECTIVES	STRATEGIES	TACTICS *(see MAP Action Plan below for further detail)*	MILESTONES/METRICS OF SUCCESS
GOALS: **Achieve improvement, transparency, and value, in pursuit of the aims, priorities, and goals of the National Quality Strategy**	**1. Improve outcomes in high-leverage areas for patients and their families (i.e., progress towards realization of the NQS)**	• Ensure recommended performance measures are high-impact, relevant, actionable, and drive toward realization of the NQS • Establish feedback loops to support data-driven decision making and build on other initiatives (e.g., NQS, NPP, private sector efforts) • Provide input on measure sets for specific applications	• Identify Families of Measures and Core Measure Sets • Enhance MAP Measure Selection Criteria • Develop MAP Analytics Function • Define Measure Implementation Phasing Strategies • Create and Execute MAP Evaluation Plan	• Program measure sets align with MAP families of measures and core measure sets
	2. Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value	• Promote alignment of performance measurement across HHS programs and between public and private initiatives • Stimulate gap-filling for high-priority measure gaps • Identify solutions to performance measure implementation barriers	• Identify Families of Measures and Core Measure Sets • Address Measure Gaps • Enhance MAP Measure Selection Criteria • Create and Execute MAP Evaluation Plan	• Funding for measure development and developer efforts focus on the highly-prioritized gaps identified by MAP • Proposed solutions to implementation barriers for existing high-leverage measures are tested in the field • Low-value measures are removed from programs
	3. Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden	• Ensure MAP's recommendations are relevant to public and private implementers and its processes are effective • Establish feedback loops with	• Identify Families of Measures and Core Measure Sets • Enhance MAP Measure Selection Criteria	• Key purchasers and payers are aware of and engaged in MAP work • MAP recommendations are implemented in public and private sector programs

	OBJECTIVES	STRATEGIES	TACTICS *(see MAP Action Plan below for further detail)*	MILESTONES/METRICS OF SUCCESS
		stakeholders to determine if MAP recommendations are meeting stakeholder needs and are aligned with their goals • Recommend removal of low-value measures from federal programs	• Establish a MAP Communication Plan • Execute MAP Engagement Plan	

Feedback Loops

The MAP strategies highlight the need for multi-directional collaboration among the many stakeholders engaged in performance measurement efforts to achieve the goals of the NQS. These efforts comprise the Quality Measurement Enterprise and include the functions of priority and goal setting, measure development and testing, measure endorsement, measure selection and use for various purposes, and determining impact. Figure 1 demonstrates the complex interactions among the functions and those entities fulfilling the functions.

Figure 1. Feedback Loops across the Functions of the Quality Measurement Enterprise.



To truly make progress against its goals and objectives, it is imperative for MAP to establish bi-directional collaboration (i.e., feedback loops) with the stakeholders involved in each of these functions. Recognizing that most of these feedback loops currently do not current exist, MAP has identified initial priority feedback loops to connect its work to each function of the quality measurement enterprise:

> Priorities and Goals. The priorities and goals established by the NQS serve as a guiding framework for the Quality Measurement Enterprise, including MAP's work. To ensure its recommendations align with the NQS, MAP will work with the NPP and other entities to understand the implications of the NQS priorities and goals and what quality measures are needed for which purposes. As MAP develops recommendations, it may identify opportunities to enhance the NQS, and will share these findings with its federal partners and the NPP.
>
> Measure Development and Testing. Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., PCPI, NCQA, The Joint Commission, medical specialty societies). Throughout its work, MAP identifies and prioritizes measure gaps. To effectively assist in addressing measure gaps, MAP needs information about measures in the development pipeline to understand which high-leverage improvement

opportunities have not yet been addressed. Further, to help identify solutions, MAP needs a deep understanding of the barriers that hinder measure development (e.g., unreliable or unavailable data sources).

Measure Endorsement. NQF endorses measures based on criteria of importance, scientific acceptability (i.e., validity and reliability), usability, and feasibility. The endorsement process generates important information for MAP decision-making, including intended use of measures, performance over time for measures undergoing endorsement maintenance review, and applicability to various settings and levels of analysis. Additionally, the endorsement process can signal where there have been attempts to fill high-leverage gaps (e.g., measures submitted that were not endorsed) and the barriers to filling those gaps to inform MAP's efforts to stimulate gap-filling.

Measure Selection and Use. Measures are used across a variety of quality measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private sector entities. To ensure MAP's input on measures for specific purposes promotes alignment across programs and sectors, MAP must understand which measures are currently used in programs and the rationale for selecting those measures (e.g., measures stakeholders find most useful, measures that end-users find difficult to report). With an increased understanding of measure selection, use, and usefulness, MAP will be able to provide more detailed recommendations, including but not limited to, implementation guidance, programmatic structure guidance, and specific recommendations for varying program purposes (e.g. payment models, public reporting programs, clinical quality improvement).

Measure Impact. Specific information on individual measures (i.e., current performance, improvement over time, unintended consequences) is essential to understand if measures are driving improvement, transparency, and value. MAP requires such information to enhance its decision-making.

Evaluation. As MAP is able to garner additional information through the establishing feedback loops, MAP's processes will continue to evolve. MAP's evaluation efforts must solicit feedback from stakeholders across the Quality Measurement Enterprise to determine if MAP is successful.

Table below 2 is an initial mapping of the collaboration needed, captured in the context of inputs to and outputs of MAP's work.

Table 2. MAP Feedback Loops

Feedback Loop	MAP Needed Inputs		MAP Outputs	
	Information	Key Stakeholders	Information	Key Stakeholders
Priorities and Goals	• NQS priorities and goals • Adoption of NQS by federal agencies and entities outside of the federal government	• NPP (multi-stakeholder group including, but not limited to, clinicians, providers, consumers, purchasers, health plans, measurement experts, accreditation/certification organizations) • Federal partners (AHRQ) • State/local agencies, regional collaboratives	• Signals where national strategies are needed (e.g., disparities)	• NPP • Federal partners (AHRQ)
Measure Development and Testing	• Measures in the development pipeline • Development issues—evidence base, data for testing	• Measure developers (e.g., PCPI, NCQA, Joint Commission, medical specialty societies) • NQF endorsement process (i.e., Consensus Standards Approval Committee, topic-specific Steering Committees)	• Identification and prioritization of gaps • Identification of gap-filling barriers	• Measure developers • NPP • NQF endorsement process • Federal partners (e.g., CMS, AHRQ, ONC, SAHMSA, HRSA, VA) • Private sector stakeholders funding measure development (e.g., medical specialty societies and certification boards)
Measure Endorsement	• Endorsed measures—important, scientifically acceptable, feasible, usable • Measures not endorsed—	• NQF endorsement process	• Identification and prioritization of gaps • Identification of gap-filling barriers • Solutions to	• NQF endorsement process • Measure developers • Federal partners (e.g., CMS, AHRQ, ONC, SAHMSA, HRSA)

Feedback Loop	MAP Needed Inputs		MAP Outputs	
	Information	Key Stakeholders	Information	Key Stakeholders
	signal where gap-filling has been attempted • Implementation challenges from maintenance process		implementation and use barriers	• Private sector stakeholders funding measure development
Measure Selection	• Current measures selected for use in programs and rationale • Rationale for accepting/rejecting MAP input	• Federal partners (HHS, VA, DoD) • State/local agencies, regional collaboratives • Purchasers, payers (e.g., health insurance exchanges) • Providers, clinicians • Accreditation/certification entities • Other public reporting entities (e.g., Consumer Reports)	• Families of measures and core measure sets • Input on measures for specific programs (e.g., adding/removing measures) • Guidance on implementing MAP recommendations	• Federal partners (HHS, VA, DoD) • State/local agencies, regional collaborative • Purchasers, payers • Providers, clinicians • Accreditation/certification entities • Other public reporting entities
Measure Use	• Current measures in use, including rationale	• Consumers/patients • Federal partners (HHS, VA, DoD) • State/local agencies, regional collaboratives • Purchasers, payers • Accreditation/certification entities • Providers, clinicians • Assessments of measure use (e.g., CMS, QASC, AHIP, RWJF,	• Measure use for varying payment models (e.g., measure domain weighting, benefit structure) • Input on programmatic structure (e.g., data collection and transmission) • Measure use for accountability • Measure use to support	• Consumers/patients • Federal partners (HHS, VA, DoD) • State/local agencies, regional collaboratives • Purchasers, payers • Accreditation/certification entities • Providers, clinicians

Feedback Loop	MAP Needed Inputs		MAP Outputs	
	Information	Key Stakeholders	Information	Key Stakeholders
		NRHI)	clinical quality improvement • Measure use to support informed choices	
Impact	• Current performance • Improvement • Unintended Consequences	• Federal partners (HHS, VA, DoD) • State/local agencies, regional collaboratives • Purchasers, payers • Providers, clinicians • Assessments of measure impact (e.g., CMS, QASC, AHIP)	• Enhance and revise MAP's recommendations and processes	
Evaluation	• Definitions of MAP's success	• Consumers/patients • Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Providers, clinicians • Accreditation/certification entities	• Enhance and revise MAP's recommendations and processes	

Why Should You Participate in MAP?

MAP seeks to establish feedback loops with you and your organization to better understand and meet your needs for performance measures and measurement information. A few examples of why it is beneficial to you to contribute to MAP's work and to use MAP's products are provided below:

If you are a…

…Consumer or patient, you need measurement information to make better decisions about where to get your healthcare. MAP needs your input on the information you find easiest to understand and most helpful. Your feedback will assist MAP in recommending measures for quality reporting programs that address your needs.

…Provider or clinician, you use measures to improve care processes and outcomes and to show the value of the services you provide. MAP needs input on your experience participating in performance measurement programs, particularly which measures you track, difficulties you have participating in the programs, and how you use measures to support improvement. MAP's work will promote consistency in measurement across programs to reduce your data collection burden and decrease confusion about where to focus your improvement efforts.

…Purchaser, you use performance measurement information to purchase healthcare services based on value, ensuring the populations you are responsible for receive high quality care that is not wasteful or harmful. MAP needs your input to understand the current measurement activities you are engaged in, particularly, which measures you use and what results you have seen.

…Payer (including federal and state agency officials), you implement programs, such as public reporting and performance-based payment programs, that use performance measures. MAP aims to assist you with structuring your programs by signaling the best available measures for specific purposes. You also fund measure development, and MAP will provide you with prioritized measure gap areas. MAP needs you feedback about which measures you use, what results you have seen, and where improvement is lagging. Further, MAP seeks your evaluation of the effectiveness of its recommendations in meeting the needs of your programs.

…Manager of a system of care (e.g., ACO), you report measures to purchasers and payers while also implementing your own performance measurement programs to assess providers and clinicians. As care delivery and financing move toward more integrated models, MAP wants to understand which measures you need to monitor and improve the health, as well as the healthcare quality and costs, of your population.

You will have the opportunity to provide comments to MAP via a feedback form that will be posted on the MAP webpage in fall 2012 regarding your experience with the measures you use.

MAP Action Plan

MAP's action plan specifies seven tactics for operationalizing its goals and objectives: (1) approach to stakeholder engagement, (2) identifying families of measures and core measure sets, (3) addressing measure gaps, (4) defining measure implementation phasing strategies, (5) analytic support for MAP decision making, (6) refining the MAP Measure Selection Criteria, and (7) evaluating MAP's processes and impact. The detailed description of each tactic includes the key participants, what MAP will produce, and when the tactic will be implemented.

1. Approach to Stakeholder Engagement

MAP has articulated the need to collaborate with multiple stakeholders across the Quality Measurement Enterprise to support data-driven decision-making and determine if MAP recommendations are meeting stakeholder needs. Accordingly, engagement must occur: (1) within MAP as a group, MAP members must bring their breadth of experiences and knowledge to allow for more informed decision-making and work to execute MAP's recommendations; (2) within MAP and with individual stakeholders, including consumers, to ensure that MAP recommendations are meaningful and reflect the perspectives and needs of stakeholders; and (3) more broadly with individual stakeholders involved in some aspect of healthcare quality measurement to determine the degree of uptake and use of MAP recommendations and related supporting materials.

Successful engagement depends on MAP members sharing expertise and learning, and using MAP recommendations. Success also depends on engaging end-users of MAP recommendations, as improvement in outcomes, alignment of measurement, and coordination across programs relies on public- and private-sector stakeholders at the national, state, and local levels applying MAP's recommendations to their own activities. MAP's approach to stakeholder engagement will establish feedback loops (discussed earlier, see Table 2) with multiple stakeholders in phases: an initial engagement phase to frame the approach and make targeted connections, and a subsequent phase defined by a MAP Engagement Task Force. Additionally, the MAP Communications Plan (see companion document) will support the engagement of key stakeholders.

Initial Engagement Phase. MAP's immediate effort to engage stakeholders relies heavily on the involvement of MAP members. First, MAP will request that its members provide practical information that MAP needs to inform its decision-making. Second, MAP members are asked to help disseminate and apply key recommendations from MAP to increase uptake in the field, across the public and private sectors at the national, state and local levels. Table 3provides an illustrative example of MAP's initial engagement activities:

Table 3. Illustrative Example of MAP's Initial Engagement Activities.

Overarching Strategy	Action by MAP	Action by MAP Members and Other Stakeholders	Desired Result
Establish feedback loops to support informed decision-making *by MAP as a group*	Identify or create methods to *request and receive insights* from stakeholders to then factor into MAP work	Provide comments or insights regarding issues that are important to MAP	MAP's deliverables reflect stakeholder perspectives and help meet key practical needs of those directly involved in measurement and improvement of health and healthcare
Establish feedback loops to support informed decision-making *by stakeholders*	Identify or create methods to *share insights and ideas* with stakeholders	Help disseminate insights and ideas from MAP to others involved in	MAP output motivates and enables stakeholders to take actions that improve

		measurement and improvement of health and healthcare	outcomes and align measurement across programs and sectors
		Apply insights and ideas from MAP in their own work in measurement and improvement of health and healthcare	

MAP will provide members structured ways to share information on measure use and implementation experience that can inform MAP decision-making. Similarly, MAP will seek stakeholder input for an array of effective ways to disseminate recommendations and deliverables from MAP (e.g., how might NQF's Quality Positioning System best be used as one method for disseminating the families of measures and core measure sets). MAP will also involve NQF's broader membership and NPP members in this two-way engagement. Examples of channels used to connect include the NQF member Councils and drawing from other NQF activities that involve soliciting information and insights from a variety of stakeholders in the field (e.g., Registry Needs Assessment, Measure Gap Report, and various NQF convenings).

Specifically, MAP's initial engagement efforts have included soliciting input from MAP members to inform the development of families of measures—collaborating with payers, purchasers, and measure developers to determine where measures are used in public and private sector efforts, identifying measure gaps, and understanding potential barriers to addressing measure gaps. Additionally, MAP has begun bi-directional communication with stakeholders engaged in understanding measure use, ensuring that the results of these efforts will rapidly be available to MAP. For example, MAP has been in contact with AHIP about their survey of measures health plans are using, with QASC about their environmental scan of measure use, and with CMS about their measure impact evaluation. Finally, MAP will actively solicit stakeholder input through a feedback form posted on the MAP web page regarding experience using measures (e.g., usefulness, implementation issues).

MAP Engagement Task Force. MAP would like to expand its reach to a broader range of stakeholders with a goal of engaging those who have not typically participated in MAP processes to this point (e.g., state and local agencies, additional regional collaboratives). MAP will pursue a more in-depth process to establish a systematic framework for creating and maintaining the bi-directional flow of information and motivating uptake of MAP recommendations, as described above. To do this, MAP will establish an Engagement Task Force. The task force will first assess the information types (e.g., measure use, measure performance over time) identified in the feedback loops and analytics sections of this strategic plan, to identify possible additional channels for engagement. Such methods may include focus groups, surveys, online discussion forums, regular submission of information by key stakeholders, targeted outreach, plus options identified through the structured assessment of the communications and outreach capabilities of MAP members. MAP will also determine the most useful content and format for materials to disseminate key information to stakeholders, with particular focus on meeting various stakeholders' needs to enable and support their uptake of MAP recommendations.

Action Plan

Collaborators (Who are the key participants?). MAP will engage multiple stakeholders to both inform and disseminate MAP's recommendations to promote uptake and ultimately achieve improved outcomes, aligned measurement, and coordinated program efforts. In addition to implementing initial engagement activities, MAP will convene a multi-

stakeholder Engagement Task Force, comprising MAP and NPP members to design a framework as the basis for a structured and systematic approach to stakeholder engagement. This task force will provide input to the MAP Coordinating Committee on needed information, methods for obtaining that information, and opportunities for dissemination to promote and support uptake of MAP recommendations.

Deliverables (What will be produced?). MAP's engagement approach supports all deliverables in the MAP Action Plan. MAP will produce a brief report with an engagement workplan that details the systematic approach to effective engagement, including strategies, tactics, channels, timing, and success metrics.

Timing (When will the products be delivered?). MAP's initial engagement is ongoing to actively seek information from stakeholders to inform MAP decision making, with growing attention to also encouraging and enabling stakeholder uptake of MAP recommendations. Specifically, MAP will post a form on its webpage in the fall of 2012 to solicit end-user feedback on measure experience. In 2013, MAP will convene the Engagement Task Force to establish a structured framework. The approach will be finalized by mid-2013, and the task force's recommendations will be phased-in.

2. Identifying Families of Measures and Core Measure Sets

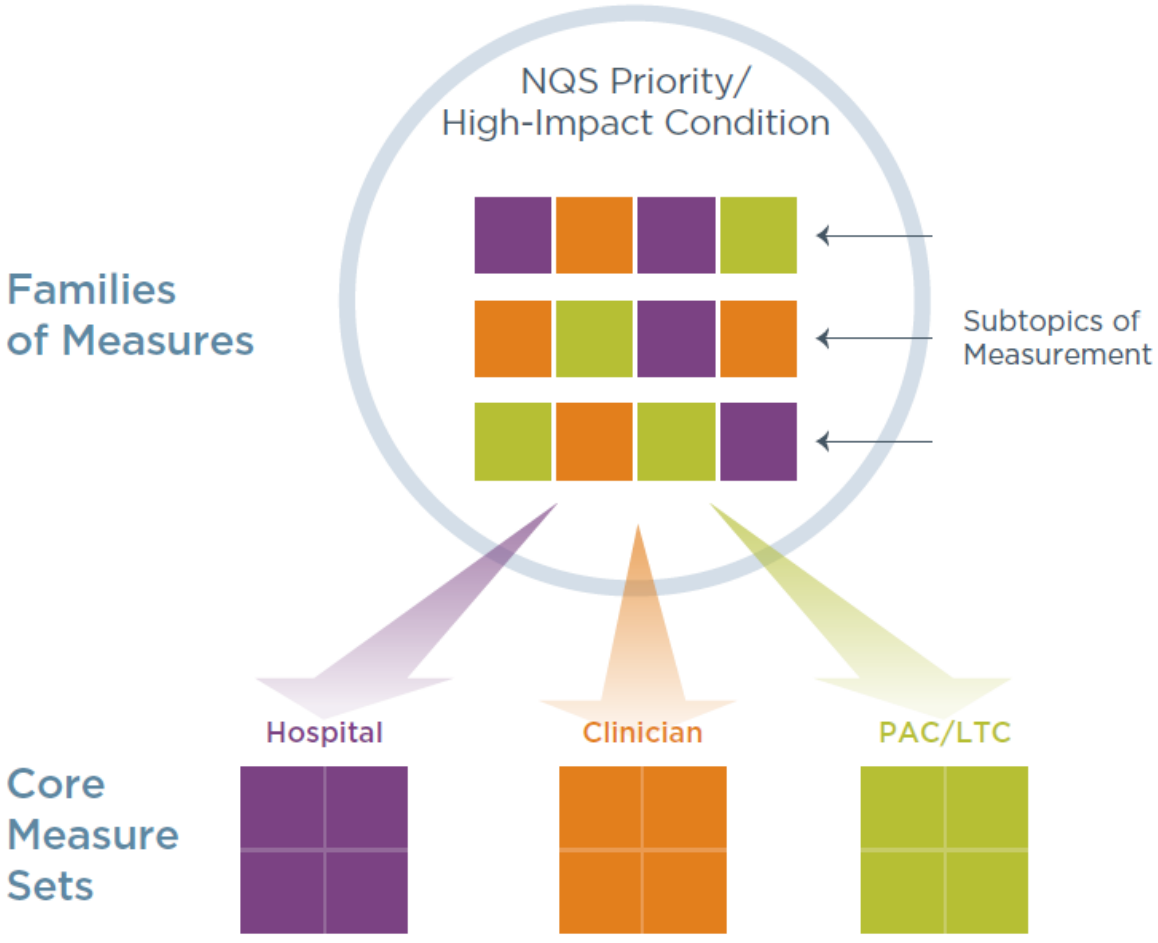
MAP's objectives aim to improve outcomes, provide consistent and meaningful information, and coordinate measurement efforts (see Goals, Objectives, Strategies, and Tactics, Table 1). To make progress on these objectives, MAP seeks to align performance measurement across HHS programs and between the public and private sectors, while identifying the best available measures to use for specific purposes. As a primary tactic to accomplish the objectives, MAP will identify families of measures to promote measure alignment and will create core measure sets to encourage best use of available measures in specific HHS and private sector programs. The families of measures and core measure sets will serve as a signal to HHS and the field of MAP's highest priorities for measurement for each topic, as well as a starting place and guide for MAP's pre-rulemaking deliberations.

Families of measures are sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities and high-impact conditions. To identify a family of measures, MAP will first ascertain and prioritize the subtopics of measurement that are considered the highest-leverage opportunities for improvement for the topic. Using the strategic opportunities and national-level measures presented in the NQS 2012 Annual Progress Report as a starting point, MAP will review impact, improvability, and inclusiveness of improvement opportunities under each subtopic giving additional consideration to cost of care—including areas of waste, inefficiency, overuse—and disparities to further prioritize the subtopics. Additionally, MAP will consider the highest-leverage improvement opportunities across the lifespan, recognizing that measurement opportunities can vary by age. Next, MAP will review the available measures that address the high-leverage improvement opportunities, gathered from the NQF-endorsed portfolio of measures, measures used in federal programs, and measures used in private sector efforts.

Using the MAP Measure Selection Criteria to provide guidance for considering if the family addresses the relevant care settings, populations, and levels of analysis, MAP will select measures for inclusion in the family. When selecting measures for the family, MAP will actively draw information and seek insights from private- and public-sector efforts; for example, the HHS Interagency Working Group on Healthcare Quality is engaging in efforts to align and coordinate performance measurement across federal programs. Measures used in initiatives, such as Partnership for Patients, the Million Hearts Campaign, and private sector programs (e.g., eValue8, IHA P4P, Bridges to Excellence, health plan value-

based purchasing programs), will be considered when selecting measures for the families. As part of the selection process, MAP will identify the high-leverage opportunities that lack appropriate performance measures as measurement gaps. Figure 2 represents the concept of families of measures.

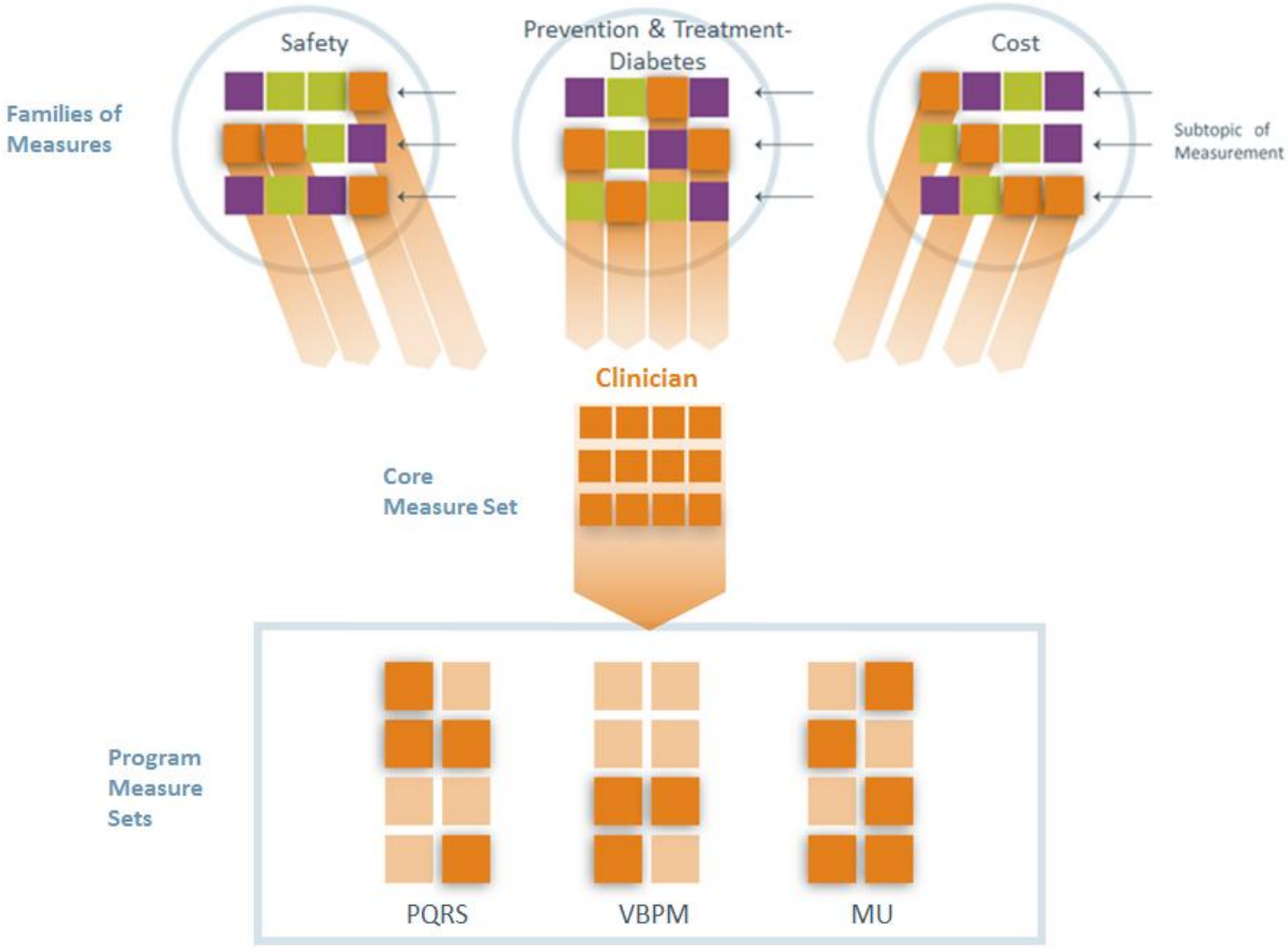
Figure 2 Families of Measures and Core Measure Sets



Core measure sets are drawn from the families of measures and consist of the best available measures and gaps for a specified care setting, population, or level of analysis. MAP will use the core measure sets to guide its pre-rulemaking

input on the selection of measure sets for specific programs, providing recommendations on how program measures sets can best align with the core set. While MAP's pre-rulemaking input is not necessarily limited to measures from core measure sets, such measures should be viewed as representing the highest-leverage opportunities for priorities areas under the NQS. Figure 3 illustrates program measure sets and core measure sets populated from families of measures.

Figure 3 Families of Measures Populating a Core Measure Set and Program Measure Sets



Action Plan

Collaborators. MAP will convene time-limited task forces, drawn from the membership of the MAP Coordinating Committee and workgroups, to identify the families of measures. Liaisons from the National Priorities Partnership (NPP) and endorsement project Steering Committees will also serve on the task forces to provide insight from the input to the NQS and from endorsement recommendations.

Deliverables. Through a phased approach, MAP will identify families of measures for each National Quality Strategy priority and several high-impact conditions (i.e., diabetes, cardiovascular disease, mental health). MAP also plans to revisit and refine the families of measures as needed; for example, if the MAP Measure Selection Criteria are enhanced

to include criteria for differing program purposes, MAP will revisit existing measure families considering the enhanced measure selection criteria. MAP may also identify families of measures to address additional high-impact conditions.

Timing. In 2012, MAP will identify families of measures for diabetes, cardiovascular conditions, safety, and care coordination. MAP chose to address these topics first as they build on MAP's prior work (e.g., MAP Safety Coordination Strategy) or represent areas in which there is a history of measure alignment issues (e.g., cardiovascular care). In 2013, MAP will identify families of measures for affordability (e.g., resource use, total cost of care, appropriateness), population health, patient- and family-engagement, and mental health. In 2014 and subsequent years, MAP will revisit existing families of measures and identify new families of measures for additional high-impact conditions.

3. Addressing Measure Gaps

Throughout MAP's work, including the identification of families of measures and core measure sets and pre-rulemaking activities, MAP will identify gaps in available performance measures. Critical measure gaps—such as patient-reported functional status, cost, care coordination, patient engagement, and shared decision-making—persist across settings and programs despite being previously identified as high-priority gaps. To ensure resources are effectively utilized and to synchronize public and private sector efforts, a coordinated approach to addressing measure gaps is needed.

MAP will serve as a catalyzing agent for coordinated gap-filling among public and private entities, engaging measure developers and those who fund measure development by: (1) identifying gaps where measures are not available or inadequately assess performance, (2) prioritizing the gaps by importance and feasibility to address, (3) presenting measure ideas to spur development, and (4) highlighting barriers to filling gaps and potential solutions to the barriers. Recognizing MAP will not itself resolve measure gaps, given that MAP neither develops nor implements measures, MAP will also identify the key stakeholders most aptly positioned to fill the measure gaps and collaborate on the development of gap-filling pathways. The NPP can assist in coordination with key stakeholders across the Quality Measurement Enterprise to lay out systematic plans to fill gaps.

The process of measure development and implementation consists of multiple steps, and granular information about measure gaps is needed at each step. When identifying measurement gaps, MAP will characterize the gaps along the measure lifecycle (Figure 4). The measure lifecycle is initiated by identification of performance gaps and measure ideas to fill those gaps, and is completed with the application and evaluation of the impact of measures.

First, high-leverage opportunities for measurement are identified as performance gaps in the NQS. Second, where no measure is available to address a performance gap, a measure gap is identified for de novo development, and measure ideas to fill the gap are generated. Third, a measure developer most aptly positioned to develop the measures looks to evidence-based practice guidelines to inform measure development, though developers are often faced with gaps in the evidence base. Fourth, measure concepts, including numerator and denominator statements and exclusions, are developed and tested. Availability of a test bed containing necessary data is another potential hurdle. During the fifth and sixth steps, measure development and testing, various measure methodological issues may arise, such as appropriate risk adjustment, level of analysis determination, attribution methodology, eMeasure specification, and data source availability.

Once measure development and testing have been completed, the measure can be brought forward for endorsement, the seventh step, to be assessed against the endorsement criteria of importance, scientific acceptability, usability, and

feasibility. Where endorsed measures are available but not yet implemented or used in appropriate programs, an implementation gap is identified, which is the eighth step. Evaluation of measure use and impact is the ninth step in the measure lifecycle. Evaluation is important to determine the extent to which a measure is driving intended improvement or unintended, undesirable consequences. Information about the impact of measures is important to support and assess MAP decision-making (see analytics and evaluation sections).

As with other entities across the Quality Measurement Enterprise, MAP will also make recommendations for addressing measure gaps at all steps in the measure lifecycle. For example, where a de novo measure gap is identified, MAP will suggest measure ideas. Where an existing measure should be considered for expansion to additional populations and settings, MAP will signal development and testing gaps recognizing that significant resources are needed to develop, test, and potentially revisit endorsement for the modified measures. Where an implementation gap exists for an endorsed measure, MAP will define a measure implementation phasing strategy.

Figure 4 Measure Lifecycle

As measure development is dependent on funding, MAP will prioritize the measure gaps to signal where funding is most needed. In prioritizing the gaps, MAP will consider the measurement needs of multiple stakeholders as their measurement priorities can vary. For example, gaps for the Medicare program largely focus on the needs of geriatric patients, while gaps for commercial health plans typically focus on the needs of chronically ill younger adults and maternity care. Once gaps are prioritized, MAP will work with measure developers, funders, and other stakeholders to identify potential barriers to filling gaps and will propose solutions.

Action Plan

Collaborators. The MAP task forces will identify measure gaps while developing families of measures. In addition, MAP workgroups will also identify measure gaps when developing MAP's pre-rulemaking input. To provide a comprehensive picture of the measure gaps and proposed options for addressing those gaps, MAP will engage the various stakeholders participating in the steps along the measure lifecycle. For example, MAP will collaborate with measure developers, funders, and program implementers to understand challenges that may be contributing to gaps.

Deliverables. Each family of measures will include a discussion of measure gaps and potential opportunities to address those gaps. Additionally, MAP's annual pre-rulemaking input will address measure development and implementation gaps.

Timing. MAP will identify and propose solutions to gaps throughout the course of its work. Initial MAP recommendations on opportunities to address measure gaps will be in identifying the 2012 families of measures.

4. Defining Measure Implementation Phasing Strategies

The families of measures and core measure sets will facilitate the use of high-impact measures that are aligned across programs and between public and private initiatives. The transition from current measure sets used in programs to the core measure sets must occur deliberately, to quickly achieve improved outcomes and to ensure the transition does not induce undue provider burden. Accordingly, MAP must define smooth measure implementation phasing strategies that delineate how program measure sets transition from current sets to the core sets.

Measure implementation phasing strategies will address how a program's purpose transitions over time; for example, some federal programs transition to pay for performance after beginning as public reporting programs. Phasing strategies will also consider the evolving mechanisms for data collection, including systems capability and capacity, best practices for collecting data needed for robust measurement, and interim strategies for data collection. For example, MAP will identify which measures in a program should be phased out as more person-centered, cross-cutting, and health information technology (HIT)-enabled measures become available. Finally, implementation phasing strategies will aim to provide solutions to the barriers that perpetuate measure implementation gaps. For example, programmatic structure (e.g., reporting time frames, need for trended data, data transmission processes) can prohibit a program measure set from transitioning to the ideal and may limit the use of measure results to one specific program.

MAP phasing strategies will provide guidance on the implementation of MAP's recommendations in the public and private sectors. As MAP evaluates HHS' list of measures under consideration during its annual pre-rulemaking deliberations, MAP's recommendations regarding individual measures for federal program measure sets will be accompanied by phasing strategies, specifically:

- **Support** represents measures for immediate inclusion in the program measure set, or for continued inclusion in the program measure set in the case of measures that have previously been finalized for the program.

- **Support Direction** represents measures, measure concepts, or measure ideas that should be phased into the program measure set over time.
- **Phased Removal** represents measures that should remain in the program measure set for now, yet be phased out as better measures become available.
- **Do Not Support** represents measures or measure concepts that are not recommended for inclusion in the program measure set. This includes measures or measure concepts under consideration that do not address measure gaps or programmatic goals as well as previously finalized measures for immediate removal from the program measure set.
- **Insufficient Information** represents measures, measure concepts, or measure ideas for which MAP does not have sufficient information (e.g., measure description, numerator or denominator specifications, exclusions) to determine what recommendation to make.

MAP will provide rationale—informed by the families of measures, core measure sets, and MAP Measure Selection Criteria—for each of its implementation phasing recommendations. For example, MAP will note for each "Support Direction" recommendation whether a measure is a core measure for that program (i.e., from the families of measures and appropriate to that setting) and cannot be implemented in the program immediately (e.g., not feasible to collect data) or whether a measure concept or idea addresses a measure gap identified in the families of measures.

Action Plan

Collaborators. MAP workgroups will develop measure implementation phasing strategies when providing MAP's annual pre-rulemaking input; however, MAP task forces may also consider measure implementation phasing when developing families of measures. MAP will engage stakeholders to provide input to ensure feasibility of MAP's phasing strategies. For example, NPP affinity groups may provide input on how MAP's phasing strategies will address the real-world implementation challenges of measurement.

Deliverables. MAP's input on each federal program will include a discussion of measure implementation phasing strategies. As applicable, MAP will provide phasing strategies for programs beyond federal programs.

Timing. MAP will define measure phasing strategies throughout the course of its work. Initial MAP phasing strategies will be included in the 2013 MAP Pre-Rulemaking Report.

5. Analytic Support for MAP Decision-Making

To drive improvement, MAP's decision-making must be systematically informed by evidence, measurement data, and experience in the field. To provide thorough recommendations on the best performance measures for specific purposes, MAP has established the following approach to analytic support:

- Build on the NQS and broader evidence to identify high-leverage opportunities for improvement;
- Utilize measurement information, including available information on measure use and impact; and
- Refine MAP's decision-making framework over time with experience and information gained from analysis to evaluate MAP's impact.

Build on NQS and broader evidence to identify high-leverage opportunities for improvement. The foundation for MAP's decision-making is the NQS. Accordingly, MAP's analytics plan incorporates NPP's input to HHS regarding strategic opportunities and national-level measures to achieve the aims, priorities, and specific goals of the NQS. MAP and NPP

will promote bi-directional collaboration to ensure MAP's decisions align with the true intent of the NQS aims and priorities. In addition, MAP will leverage findings from other initiatives focused on advancing healthcare quality. Specifically, MAP will actively seek information that describes impact, inclusiveness, and improvability for high-impact improvement opportunities, with a focus on incidence, prevalence, cost, and regional variation. For example, *The Healthcare Imperative: Lowering Costs and Improving Outcomes,* published by the Institute of Medicine (IOM), will provide MAP with valuable information regarding opportunities to address healthcare waste and resource use. Broader healthcare quality research and measure endorsement information will facilitate MAP's articulation of the highest-leverage opportunities for performance measurement.

Utilize measurement information, including available information on measure use and impact. The NQF endorsement process evaluates measures for importance, scientific acceptability, usability, and feasibility. Accordingly, the NQF endorsement process provides insights into measure applicability across settings and populations, the use of measures, measurement challenges, and measure gaps. MAP will incorporate information gleaned from the endorsement process to inform its decision-making. MAP also requires information on the use and impact of existing measures—including experience using measures, unintended consequences, measure benchmarks, and trends—to make informed decisions about the best available measures for specific purposes. MAP will request information from stakeholders who are assessing measure use and impact, including, but not limited to, federal efforts (e.g., CMS' *National Impact Assessment of Medicare Quality Measures Report*, which provides trended data for CMS programs; the Agency for Healthcare Research and Quality's (AHRQ) National Healthcare Quality and Disparities Reports and Healthcare Cost and Utilization Project; and the Centers for Disease Control and Prevention (CDC) and other federal surveillance data), state and community efforts (e.g., regional data collaboratives, state Medicaid data, the University of Wisconsin County health data), and private sector efforts (e.g., medical specialty societies, The Commonwealth Fund, the Quality Alliance Steering Committee's (QASC) Environmental Scan, the American's Health Insurance Plans' survey of measure use by health plans, the National Committee for Quality Assurance).

MAP's approach to stakeholder engagement will identify rapid-cycle processes for obtaining information from existing sources, as close to real-time as possible, to inform MAP decision-making. For example, CMS and The Joint Commission have established methods for gathering feedback on measure implementation issues. MAP will also collaborate with experts to identify innovative methods for predicting which measures would best address performance gaps, though evidence to inform predictive modeling approaches is limited.

Inform MAP's evaluation and refine MAP's decision-making framework over time. Recognizing MAP's iterative processes, MAP's work will continually inform its future decisions. Similarly, MAP must determine if its recommendations and supporting materials are meeting stakeholder needs. To accomplish this, MAP assesses the uptake of its recommendations and will conduct outreach to understand the rationale for concordance or discordance with its recommendations.

Table 4 below summarizes the desired information to facilitate and enhance MAP decision-making, categorized by the three aspects of the analytics plan mentioned above. Needed information is further classified by data type including qualitative and quantitative, primary sources to collect data, planned use of information, and the extent to which the information is available. The thoroughness of MAP decision-making relies on the availability of the desired information. In the absence of the required information, MAP's work will be hampered.

Table 4 Information Needed to Support MAP Decision-Making

Information Type	Information Category	Primary Sources	Planned Use	Availability of Information
Background/Evidence				
Priorities	Qualitative	NQS, NPP	Guiding framework	Readily available
Specific goals (e.g., aspirational targets)	Quantitative	NQS, other HHS Frameworks (e.g., Partnership for Patients, Million Hearts Campaign, Healthy People 2020)	Guiding framework	Moderate—readily available for some areas, not available for other areas
Background research (e.g., incidence, improvability, inclusiveness)	Qualitative, quantitative	HHS data, IOM reports, research studies	Prioritization of high-leverage opportunities	Moderate—readily available for some areas, not available for other areas
Measure gap areas	Qualitative, quantitative	NQF, HHS reports, IOM reports, QASC, stakeholder input, measure developers	Create measure families; define gap-filling pathways	Moderate—gaps readily available; gap characterization and barriers are not available
Measurement Information				
Measure elements (e.g., specifications, applicable care settings)	Qualitative, quantitative	NQF endorsement process, AHRQ's National Quality Measures Clearinghouse	Provide detailed information on individual measures	Readily available
Measure performance results, benchmarks, and thresholds	Quantitative	HHS reports, measure developers, NQF endorsement process, publicly reported results	Assess trends and variability of results	Moderate
Implementation of measures	Qualitative, quantitative	HHS rules and reports, NQF Alignment tool, QPS portfolios, QASC, private sector programs	Determine where and how measures are being used and identify barriers	Moderate
Unintended consequences of measure use	Qualitative	NQF endorsement process, NQF's QPS tool, stakeholder input	Additional considerations for MAP decision-making	Limited
Measure impact	Qualitative, quantitative	HHS reports; selected outcome and patient experience measures results; stakeholder	Feedback to inform future MAP decision-making	Limited

Information Type	Information Category	Primary Sources	Planned Use	Availability of Information
		input		
MAP Evaluation and Ongoing Enhancements to Decision-Making				
MAP deliberations, recommendations, and input	Qualitative	MAP meeting summaries and reports	Provide history and content; inform future MAP decision-making	Readily available
Uptake of MAP recommendations and rationale	Qualitative, quantitative	HHS proposed/final rules; measure sets used in non-federal programs	Evaluate impact of MAP input; inform future MAP decision-making	Moderate

Action Plan

Collaborators. MAP will seek input from NPP co-chairs serving on the MAP Strategy Task Force and NPP liaisons to the MAP task forces to identify the high-leverage opportunities for improvement and associated priorities for measurement. To collect measure use and impact information, MAP will utilize the NQF membership councils, as well as additional stakeholders who are implementing performance measurement and evaluating measures. To supplement its work, MAP will be engaged in and review the results of research conducted by other entities, such as CMS, AHRQ, QASC, AHIP, and IOM. For a detailed list of potential stakeholders, please refer to Table 4 above and the Feedback Loops Table (Table 2).

Deliverables. Information gathered through the analytics plan will inform the development of families of measures and core sets and facilitate annual pre-rulemaking activities.

Timing. In 2012, MAP will begin compiling, organizing, and synthesizing information that is readily available to support the development of the Safety, Care Coordination, Diabetes, and Cardiovascular measure families and core sets and to assist in the selection of measures for federal programs. MAP will continue to refine this process, as new information becomes available.

6. Refining the MAP Measure Selection Criteria

The MAP Measure Selection Criteria (MSC) guide MAP's input on the selection of measures and measure gap identification, ensuring that MAP's decisions address its objectives. MAP envisions that the MSC will continue to evolve as MAP gains experience using the criteria. Over time, MAP will revisit the selection criteria to ensure its goals and objectives are clearly articulated within the criteria and address issues raised. Planned enhancements to the MSC may include:

- Addressing fit for different programmatic purposes, such as public reporting and performance-based payment;
- Expanding the high-impact conditions beyond the Medicare and pediatric populations; and
- Adding measure removal criteria.

Addressing fit for different programmatic purposes. MAP provides input on programs that use measurement for multiple purposes (e.g., public reporting, performance-based payment, clinical quality improvement) and attribute measurement results to varying levels of analysis (e.g., individual clinicians, multi-disciplinary teams, systems, communities). After its first year of pre-rulemaking input, MAP concluded that different programmatic purposes may require selecting different measures. For example, measures that are used in public reporting for use by consumers and purchasers must be relevant to audiences without a medical background, as well as important to providers/clinicians and those implementing public reporting programs. MAP will explore how the MAP Measure Selection Criteria could be revised to address attribution at varying levels of analysis and to identify measures best suited for different programmatic purposes.

Expanding the high-impact conditions beyond the Medicare and pediatric populations. MAP Measure Selection Criterion #3 (see Appendix C for MAP MSC) assesses whether a program measure set adequately addresses high-impact conditions, which are drawn from NQF's prioritized lists of high-impact conditions for the Medicare and pediatric populations. These populations are important, but the list fails to account for more than 60 percent of the U.S. population. State and private sector programs that could take cues from MAP's recommendations involve the care of adults between ages 18 and 64. As such, the current lists of high-impact conditions are not sufficient as MAP inputs. To achieve applicability across the lifespan, a MAP Technical Expert Panel (TEP) will analyze the improvement opportunities and prioritize additional high-impact conditions relevant to adults ages 18-65 and to maternal/neonatal conditions. MAP will also briefly revisit the Medicare and child health high-impact conditions to ensure the prioritization reflects the current evidence base.

Adding measure removal criteria. The families of measures and core measure sets establish the ideal. As program measure sets progress toward the ideal, measures that are determined to be less desirable (i.e., measures that are topped-out, do not support parsimony, have implementation issues, result in unintended consequences) will need to be removed from programs in order to reduce data burden and avoid misdirection of provider improvement efforts. Accordingly, MAP will develop criteria for removal of low-value measures.

Action Plan

Collaborators. The MAP Strategy Task Force will develop proposed revisions to the MAP MSC for consideration by the MAP Coordinating Committee. As an initial step, MAP will convene a multi-stakeholder Technical Expert Panel (TEP) drawn from MAP's membership to develop high-impact conditions for additional age groups.

Deliverables. Refined MAP Measure Selection Criteria that address different programmatic purposes, expand the high-impact conditions, and include a measure removal criterion.

Timing. Experts exploring ways to address varying programmatic purposes will conduct work in late 2012. The TEP will convene in early 2013. MAP will review proposed revisions to the MAP MSC in mid-2013 and finalize the next version of the MAP MSC by October 2013, prior to the 2013 pre-rulemaking activities.

7. Evaluating MAP's Processes and Impact

Periodic evaluation will gauge the effectiveness of MAP's processes and recommendations and determine whether MAP is meeting stakeholders' needs. Evaluation also serves as an opportunity to inform and enhance MAP's subsequent decision-making. MAP's evaluation approach includes ongoing, short-term evaluation and a long-term, independent

evaluation. MAP will convene a multi-stakeholder Evaluation Advisory Panel (EAP) to guide MAP's short- and long-term evaluations.

Short-term evaluation. MAP's ongoing evaluation focuses on determining the uptake of MAP's recommendations and related support materials to inform future MAP's decision-making. As an initial step, MAP will determine the concordance of its recommendations with the measures proposed and finalized through HHS rulemaking for use in federal programs. MAP will conduct outreach (as part of MAP's overall engagement plan) to other stakeholders selecting measures for use in state, regional, and private reporting programs to determine their needs as end-users along with the uptake of MAP's recommendations and the rationale for concordance and discordance with MAP's recommendations. MAP will collaborate with NPP to leverage input from the broad NPP network of performance measurement end-users.

Long-term evaluation. While ongoing evaluation will allow MAP to assess whether its recommendations and related support materials are meeting stakeholder needs in the short-term, a longer-term evaluation strategy will be needed to assess MAP's impact over time. MAP will conduct an independent third-party evaluation to determine whether MAP is meeting its objectives. The initial phase of the evaluation will build on the milestones and metrics of success established in the MAP strategic plan, to determine the evaluation logic model, research questions, and evaluation protocol. The evaluation protocol will describe data collection (i.e., surveys, key informant interviews, case studies, focus groups) and data analysis methodologies.

Action Plan

Collaborators. MAP will conduct targeted outreach to stakeholders selecting measures for use to understand the rationale for concordance and discordance with MAP's recommendations. The MAP EAP will provide input to the logic model, research questions, and evaluation protocol, and will provide initial feedback on the results of the third-party evaluation. MAP will subcontract with an independent third-party evaluator to conduct the long-term evaluation.

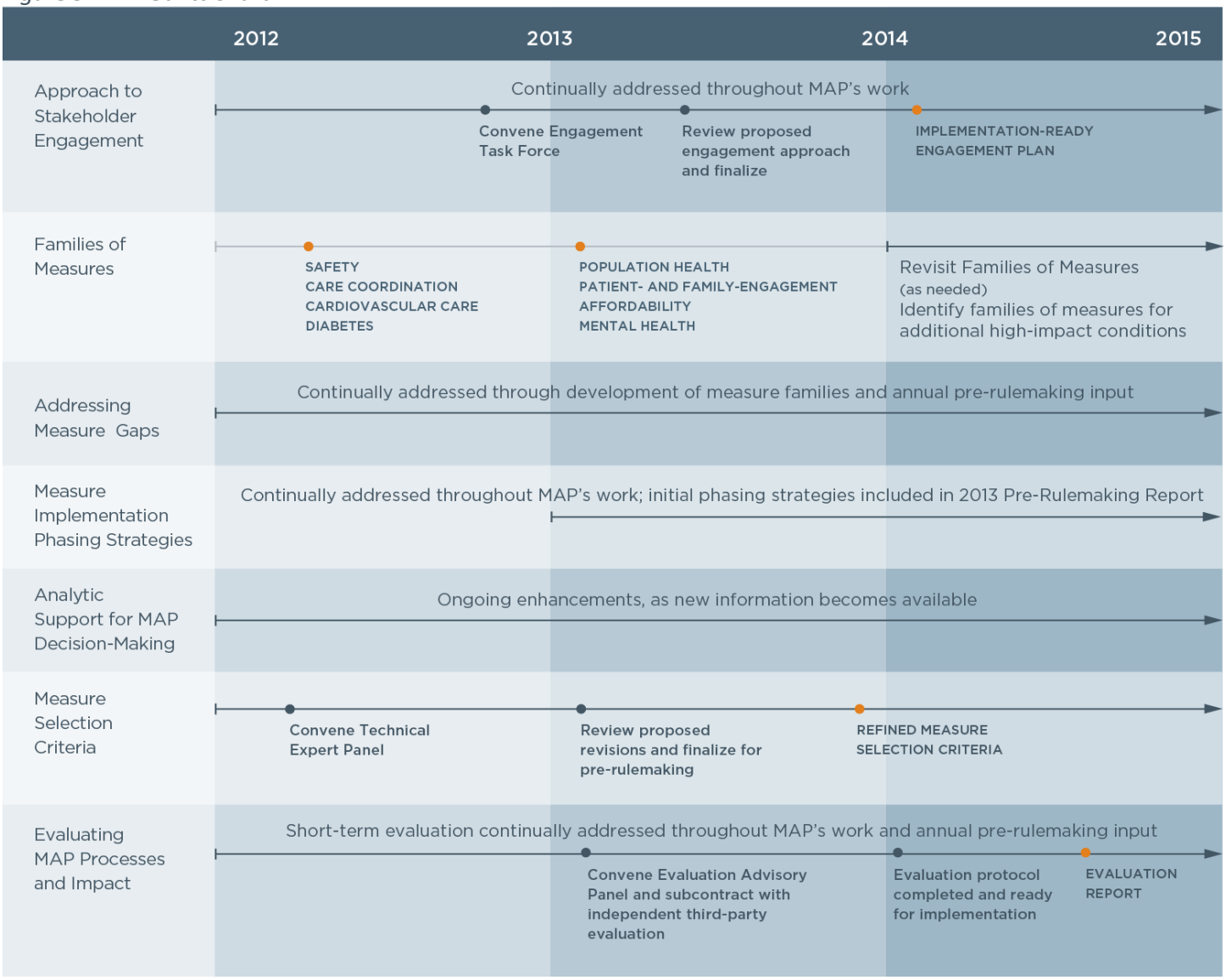
Deliverables. MAP will analyze and report on the uptake of MAP's recommendations in its annual Pre-Rulemaking Report. MAP will also produce a report of the long-term evaluation findings.

Timing. MAP short-term evaluation is ongoing. MAP will report on uptake of its recommendations in its annual Pre-Rulemaking Report in February of each year. In early 2013, MAP will call for nominations for the Evaluation Advisory Panel. The panel will convene later in 2013. MAP will select and NQF will subcontract with an independent third-party evaluator in late 2013. The evaluation protocol will be completed and ready for implementation in 2014. MAP's Evaluation Report will be completed in late 2014.

MAP Three Year Timeline

The Gantt chart below provides a summary of the action plan to execute the MAP tactics including corresponding timelines and deliverables for each tactic in the next three years.

Figure 5 MAP Gantt Chart.



MAP Communications Plan

Overview

A little more than a year since its inception, MAP has succeeded in delivering on its major deliverables and year one objectives. The primary audience in year one was a federal audience, as reflected in the multiple coordination strategy reports and MAP's first-ever pre-rulemaking report delivered to HHS February 1, 2012. A strong foundation for MAP work is being built thanks to its partners and many contributors to date.

However, to reach its longer-term goals as articulated in this plan, MAP must increase two-way engagement with stakeholders and tell a clear, compelling story about the societal challenges MAP seeks to help solve and where each stakeholder can play a specific role. Implicit in this is expanding MAP's reach outside the Beltway, and ensuring MAP strategies, materials, and outreach tactics are designed to effectively reach audiences that may be much less familiar with policy jargon, the MAP itself, the National Quality Strategy as the national blueprint for making health and healthcare more value-driven, and how this work connects to other organized efforts designed to accelerate healthcare improvement.

This communications plan is designed to support engagement of key stakeholders in MAP's work. The MAP approach to stakeholder engagement is largely focused on establishing stronger feedback loops between those who set national healthcare improvement priorities, develop measures, and use measures – and those who are helping recommend measures for use in federal and private accountability efforts. A secondary goal is to help raise awareness of the need for more coordinated use of performance measures as a way to develop a truly information-rich, value-driven healthcare system that enables better decision-making.

Strategy

The exercise of creating a three-year strategic plan for MAP has emphasized one key point: the necessity for a two-way engagement between MAP and end-users. MAP is designed in such a way that its outputs reflect inputs from end users in the field. This is an important message to stress over the course of communications activities, and is a guiding principle for what communications efforts to prioritize (i.e., focus on tactics that will help stimulate stronger engagement).

As a partnership, all MAP members play a vital role in driving the execution of this communications plan, as a way to achieve broader engagement and awareness. This plan is designed to leverage partner assets, and relies on materials developed centrally (at NQF) but tailored and distributed in a decentralized fashion. Audiences targeted in the engagement plan will be prioritized with respect to communications activities.

An important aspect of this plan is the need to participate in feedback loops – bi-directional information sharing between MAP and its stakeholders. These loops are designed to keep the flow of information into and out of MAP in a consistent and meaningful way to meet the goals and objectives spelled out in the MAP Action Plan.

This communications plan will lay out a set of recommended activities by year, with specific focus on the first year. Tactics for subsequent years will necessarily evolve based on the needs of the programs and available funding. It is important to note that some, but not all, communications activities are funded under the current MAP scope of work.

Certain activities included in the communications and engagement plans may require additional sponsorship, either from a MAP member or a to-be-determined funder.

Target Audiences

The audiences we are most focused on reaching include measure developers, funders of measure development, purchasers and payers, providers and clinicians, consumer advocates, and leaders involved in measurement at the state and community level. These audiences will sync closely with those established in the MAP approach to stakeholder engagement, and as all of MAP's processes and outputs are transparent, no one stakeholder will find themselves "left out."

The goals for reaching these audiences include:

- Improving stakeholder engagement by creating or enhancing existing feedback loops
- Increasing participation in the MAP process, as seen in more comments submitted, participation in MAP convenings, etc.
- Increasing awareness of the problems MAP is trying to help solve
- Providing greater clarity of the MAP work's value to both the public and private sector – specifically those who provide, pay for, and receive healthcare services

Importantly, the notion of "direct to consumer" has been raised during MAP strategy task force meetings. This plan seeks to clarify that MAP is not resourced or positioned at this time to launch a direct-to-consumer awareness and education campaign – nor do we advise this as the next step relative to enhancing stakeholder engagement in creating feedback loops. That said, the consumer perspective is integral in achieving a culture of measurement that is patient-centric and generated information that helps consumers make informed health and healthcare choices. The MAP communication plan recognizes the power of consumer advocacy organizations to help in meeting this essential component.

Messaging

MAP messaging can be developed centrally, but to be truly effective, will need to be carried forward by a wide variety of messengers that have reach far beyond the MAP table. These messengers include MAP members; members of other NQF initiatives, including the National Priorities Partnership and Endorsement Steering Committees; and NQF Staff. MAP members in particular have an important role to play in advancing this plan as laid out, owning its progress, and helping to refine its approach as the work evolves.

Core messages include:

- A new effort exists today to help unify everyone that pays for and delivers healthcare with respect to use of measures. Called the Measure Application Partnership (MAP), its participants seek to recommend optimal measure use for a variety of accountability and payment programs. MAP's work is intended to help both public and private sectors make connected, better decisions about optimal measure use.

- Use of performance measures makes our healthcare system information-rich and enhances overall healthcare decision-making by those who pay for, deliver, or receive healthcare services. Without measures, people are left to make decisions

based on hunches or intuition -- and we need more than that to improve health and healthcare.

- Currently, performance measures are used inconsistently – impeding our national quest to achieve a value-driven healthcare system.

- MAP's success hinges on a constant "input-output" cycle from the measurement field. Feedback from all measure users is key to MAP making better recommendations.

Tactics

In order to successfully accomplish the goals of this plan, a number of internal (NQF-staff driven) and external (the entire group of messengers) tasks need to be accomplished. These tasks and tactics will grow and change over the course of three years, but will maintain the basic principle of promoting two way engagement.

Year One

Year one will focus on creating basic messaging and materials for all stakeholders and audiences that are designed to be both clear and encouraging of engagement opportunities. Ensuring that all MAP members can tell the same story is critical relative to expanding engagement more rapidly.

Goal:

Building a foundation. Communicate importance and goals of MAP to members' own organizations. Seek out opportunities to spread message beyond your organization in the coming year.

Materials (provided by NQF):

- One-pager describing what MAP is and its function
- Core set of power point slides outlining the basics of MAP
- A tough-questions guide for internal use
- A frequently asked questions guide for external use – geared around plain English explanations, how to effectively get involved, and what is at stake
- A messaging guide for internal use by members of MAP
- Canned newsletter articles outlining what MAP is, updates on recent reports, and providing information about feedback loops
- Infographic outlining what MAP is and how it relates to other work being done at NQF and with other NQF-convened groups
- "Making connections" documents, illustrating how the work of individual groups within NQF (MAP, NPP, other NQF affiliated stakeholder groups) connects and informs the work of other groups. This can be accomplished with a voiced-over PowerPoint deck, pictorials, and other fact sheets.
- Digital toolbox to contain all important materials – one pagers, fact sheets, reports, power point slides, etc. – allowing for centralized repository of materials that can be de-centrally tailored and distributed
- Continued build-out of NQF's MAP web presence, with explicit links to places within NQF that feedback can be provided such as the Quality Positioning System, the new under-development NPP Action Registry, etc.
- A plan for outreach to all NQF Councils, tailored to each group
- Inventory of MAP partner communications assets, starting with the coordinating committee, and later creating specialized inventories based on work groups and subject matter experts.

Opportunities – MAP Members:

- Present an overview of MAP to key staff at your organization
- Tailor and disseminate NQF-created materials to better reach organizations you regularly connect with
- Include materials about MAP in upcoming, scheduled presentations
- Utilize your organization's social media resources, such as Facebook, blogs, and Twitter to share information about MAP, its accomplishments, finalized work products, meetings, reminders about public comment and participation opportunities, requests for input to be utilized in feedback loops, etc.
- Disseminate MAP materials at your own or other external meetings, encouraging peers and colleagues to participate in building effective feedback loops, joining public meetings, and providing insight during commenting periods to ensure stronger bi-directional communication
- Host a meeting specifically designed around building measure use feedback loops (note this would require additional funding)

Opportunities: NQF Staff

- Draft materials (October 2012)
- Outreach to communications staff of MAP members to compile the MAP member communications inventory (November 2012)
- Educate staff about MAP and how it relates to the work of NQF (December 2012)
- Review accomplishments and set goals for increased engagement in year two (June 2012)

The communications plan and related tactics will evolve from year one to two based on current projects and funding.

NQF Staff Deliverables

Action/Deliverable	Timeframe/Deadlines
One-pager describing what MAP is and its function	October 2012
Core set of power point slides outlining the basics of MAP	October 2012
A tough- questions guide for internal use	October 2012
A frequently asked questions guide for external use	October 2012
A messaging guide	October 2012
Canned newsletter articles	October 2012
Making connections document	October 2012
Communications inventory	December 2012
Infographic outlining what MAP is and how it relates to other work being done at NQF and with other NQF-convened groups	Early 2013
Toolbox to contain all important materials – one pagers, fact sheets, reports, power point slides, etc.	Early 2013
Educate staff about MAP and how it relates to the work of NQF	Early 2013
Review accomplishments and set goals for increased engagement in year two	End of 2013
Outreach to communications staff of MAP members	Early 2013

ROSTER FOR THE MAP COORDINATING COMMITTEE

CO-CHAIRS (VOTING)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
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 Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Doris Peter, PhD
Federation of American Hospitals	Chip N. Kahn
LeadingAge (formerly AAHSA)	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 Bechtel, MA
Pacific Business Group on Health	William Kramer, MBA

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Health Resources and Services Administration (HRSA)	Ahmed Calvo, MD, MPH
Office of Personnel Management/FEHBP (OPM)	John O'Brien
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD

ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING)	REPRESENTATIVES
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O'Kane, MHS
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

ROSTER FOR THE MAP STRATEGY TASK FORCE

CO-CHAIRS (VOTING)
Chip Kahn
Gerry Shea

MEMBERSHIP (VOTING)	REPRESENTATIVES
MAP Coordinating Committee co-chair	George Isham, MD, MS
MAP Coordinating Committee co-chair	Beth McGlynn, PhD, MPP
MAP Clinician Workgroup chair	Mark McClellan, MD, PhD
MAP Dual Eligible Beneficiaries Workgroup chair	Alice Lind, MPH, BSN
MAP Hospital Workgroup chair	Frank Opelka, MD, FACS
MAP Post-Acute Care/Long-Term Care Workgroup chair	Carol Raphael, MPA
MAP Coordinating Committee member	Christine Bechtel, MA
National Priorities Partnership co-chair	Helen Darling
National Priorities Partnership co-chair	Bernie Rosof, MD, MACP

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH

MAP "WORKING" MEASURE SELECTION CRITERIA

NATIONAL QUALITY FORUM

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

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

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

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

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

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

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

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

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

NQS priority is adequately addressed in the program measure set

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

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

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

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

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

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

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

Subcriterion 4.1	Program measure set is applicable to the program's intended care setting(s)
Subcriterion 4.2	Program measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.3	Program measure set is applicable to the program's population(s)

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

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

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

Subcriterion 5.1	Outcome measures are adequately represented in the program measure set
Subcriterion 5.2	Process measures are adequately represented in the program measure set
Subcriterion 5.3	Experience of care measures are adequately represented in the program measure set (e.g. patient, family, caregiver)
Subcriterion 5.4	Cost/resource use/appropriateness measures are adequately represented in the program measure set
Subcriterion 5.5	Structural measures and measures of access are represented in the program measure set when appropriate

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

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

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

Subcriterion 6.1	Measures within the program measure set are applicable across relevant providers
Subcriterion 6.2	Measures within the program measure set are applicable across relevant settings
Subcriterion 6.3	Program measure set adequately measures patient care across time

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

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

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

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

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

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

8. Program measure set promotes parsimony

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

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

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

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

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

Table 1: National Quality Strategy Priorities

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

Table 2: High-Impact Conditions:

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

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

MAP "WORKING" MEASURE SELECTION CRITERIA INTERPRETIVE GUIDE

NATIONAL QUALITY FORUM

Instructions for applying the measure selection criteria:

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

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

FOR CRITERION 1 – NQF ENDORSEMENT:

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

1. **'Importance to measure and report"**–how well the measure addresses a specific national health goal/ priority, addresses an area where a performance gap exists, and demonstrates evidence to support the measure focus;
2. **'Scientific acceptability of the measurement properties'** – evaluates the extent to which each measure produces consistent (reliable) and credible (valid) results about the quality of care.
3. **'Usability'-** the extent to which intended audiences (e.g., consumers, purchasers, providers, and policy makers) can understand the results of the measure and are likely to find the measure results useful for decision making.
4. **'Feasibility'** – the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measures.

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

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use
- whether the scope of the project/measure set is relatively narrow
- time-sensitive legislative/regulatory mandate for the measure(s)
- Measures that are NQF-endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges

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

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

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

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

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

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

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

- **Care settings include:** Ambulatory Care, Ambulatory Surgery Center, Clinician Office, Clinic/Urgent Care, Behavioral Health/Psychiatric, Dialysis Facility, Emergency Medical Services - Ambulance, Home Health, Hospice, Hospital- Acute Care Facility, Imaging Facility, Laboratory, Pharmacy, Post-Acute/Long Term Care, Facility, Nursing Home/Skilled Nursing Facility, Rehabilitation.
- **Level of analysis includes:** Clinicians/Individual, Group/Practice, Team, Facility, Health Plan, Integrated Delivery System.
- **Populations include:** Community, County/City, National, Regional, or States. Population includes: Adult/Elderly Care, Children's Health, Disparities Sensitive, Maternal Care, and Special Healthcare Needs.

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

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

1. **Outcome measures** – Clinical outcome measures reflect the actual results of care.[1] Patient reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[2]
2. **Process measures** – Process denotes what is actually done in giving and receiving care. [3] NQF-endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[4]
3. **Experience of care measures** – Defined as patients' perspective on their care.[5]
4. **Cost/resource use/appropriateness measures** –

   a. Cost measures – Total cost of care.

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

   c. Appropriateness measures – Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[7]
5. **Structure measures** – Reflect the conditions in which providers care for patients.[8] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FOR CRITERION 8 – PROGRAM MEASURE SET PROMOTES PARSIMONY:

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

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

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

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

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