National Quality Forum

Comments on Proposed Member Selection Criteria, Member Responsibilities, and Operating Procedures for a Partnership for Applying Measures (PAM)

The following are the comments received during the Member and Public Comment Period from July 20, 2010 – August 18, 2010. The table below includes the comments received through the online submission tool followed by comment letters submitted via email. The comments are in alphabetical order by organization.

Organization Contact	Comment	Topic
Judith Cahill, Academy of Managed Care Pharmacy	The Academy of Managed Care Pharmacy (AMCP) has concerns about redundancy among the various current initiatives to fill the quality gaps through development of quality measures. AMCP asks that the National Quality Forum (NQF) clarify how the new Partnership for Applying Measures to Improve Quality will coordinate with the National Priorities Partnership, NQF's Prioritization of High-Impact Steering Committee, NQF's current measure endorsement process, and the existing quality alliances (AQA, HQA, PQA). We do question whether the Patient-Focused Coordinating Committee would be redundant of the current Quality Alliance Steering Committee (QASC). We believe it would be beneficial to define the roles of each initiative and to eliminate duplication of efforts. Each of these initiatives and organizations serves an important role. It will be essential for NQF to not only convene groups but also to help to ensure that activities are complimentary and not redundant.	General Comments
	Comments in Attachment A on "Establishment of a Partnership for Applying Measures to Improve Quality" indicate that the new activities of the Partnership for Applying Measures to Improve Quality should be carefully coordinated with activities of the current quality alliances. In coordinating the input of the multiple standing groups, it is important for NQF to recognize the diversity of the individual constituencies. It appears from this statement that the current quality alliances would retain their autonomy. The Academy supports such autonomy and would not support the NQF Board having the authority to evaluate whether there was a need for multiple standing groups or dictating the operating guidelines for the individual alliances. PQA, a pharmacy quality alliance, has been independently organized as a 501(c)3 organization, financially supported by its member organizations. AMCP believes that the PQA Board of Directors should retain autonomy for determining PQA's operations. Although it appears that would be the intent of NQF with this proposal, AMCP would like specific clarification of this relationship.	General Comments

Organization Contact	Comment	Topic
Judith Cahill, Academy of Managed Care Pharmacy (cont.)	The Academy of Managed Care Pharmacy supports NQF's proposed criteria for selection of organizations to serve as part of the Patient-Focused Coordinating Committee and the specific provision that "Organizational Partnership members should contribute to a balance of stakeholder interests." It is essential that stakeholders from the pharmacy and prescription drug plan sector be involved, particularly as measures are discussed relating to Medicare Part D, appropriate medication use, and medication therapy management. Appropriate medication therapy is an essential component of patient care. Medications are involved in 80% of all treatments, and up to 32% of all hospital admissions are the result of adverse medication events. The pharmacist is the medication therapy specialist whose training and expertise address these patient care instances. The Academy and other pharmacy organizations are focused on quality improvement activities through PQA, a pharmacy quality alliance, and other efforts. National recommendations related to health care and the selection of measures for public reporting and payment programs must not be developed without the input of the pharmacy profession. Lack of a pharmacy perspective would ignore an essential component of positive patient care. AMCP strongly urges NQF to include a representative from the profession of pharmacy on the Patient-Focused Coordinating Committee and to include a multi-stakeholder workgroup focused on pharmacy.	Membership Criteria
Kenneth Henriksen, Advocate Physician Partners	The proposed criteria for selection of organizations for the multi-stakeholder group appears to limit participation to only those groups that 'represent leading stakeholders' affected by the use of quality measures. It is hoped that these representatives are not limited to health policy setting organizations; it would be valuable to this process to have a subset of organizational members that can speak first hand to the impact and resource commitment associated with adopting and administering measures for public reporting and quality improvement in the institutions that must collect and report on the measures (internally and externally).	General Comments
	The document - Partnership for Applying Measures to Improve Quality - is well written and sets a strong framework for the PAM. Upon reflection, it did not appear that there would be a term limit applied to the members selected for the Coordinating Committee or three sub-Committees. Having a term limit would allow for participation of a broader number of organizations or individuals in the PAM committee activities. It would also provide a mechanism to strengthen the participation of a variety of viewpoints into the work of the committees.	Membership Criteria
Alanna Goldstein, American Geriatrics Society	When rewards and penalties are instituted based on quality measurement and improvement, there is a tendency to solicit healthier patients and to avoid those who may be at risk by age, or function, or socioeconomic status. Members of the committee should be sensitive to this. Use of appropriate measurement methodology, and accounting for those high risk populations is essential to avoid selection bias.	General Comments

Organization Contact	Comment	Topic
Alanna Goldstein, American Geriatrics Society (cont.)	The Patient-Focused Coordinating Committee and the advisory work groups should have geriatrics representation. It is paramount that geriatrics expertise be included on these panels to ensure that the unique care needs of frail or vulnerable adults are considered. It is also important that members have: • Experience in applying evidence based criteria in a clinical practice setting and analysis of patient specific data; • Relevant past experience on boards and/or committees involving quality; • Experience beyond specialty (helpful but not absolutely required); and • Recognition of the socioeconomic, functional, and health literacy diversity of the populations to be considered by the committee (essential).	Membership Criteria
	In addition to the member responsibilities described by NQF, we suggest the following additions: • Require attendance at, and participation in, in-person and teleconference meetings; • Input should not be limited to specialty-specific participation alone, though sharing of that member's specialty-specific expertise is expected; • Member's input should be analysis and solution-oriented, and not reactionary; and • Members should consider impact of their decision making on all health care populations when applying quality measures.	Membership Responsibilities
	In addition to agenda items brought forward by NQF, items should also be solicited from the committee membership. Additionally, there should be: • Consensus decision making whenever possible, and decision making by supermajority when consensus is not possible; • Overlapping terms of service; and • Consultation with experts outside the committee on issues such as the financial impact of applying measures and predictive modeling.	Operational Procedures
Nancy Foster, American Hospital Association	The American Hospital Association appreciates the opportunity to comment on the proposed member selection criteria, member responsibilities, and operating procedures for the Partnership for Applying Measures to Improve Quality (PAM). We are pleased that the NQF continues to refine the draft procedures for the PAM, and we applaud the NQF for its transparency in soliciting public comment on its approach. We offer the following suggestions to further refine the PAM procedures and add clarity to the roles of the Patient-Focused Coordinating Committee and individual workgroups.	General Comments

Organization Contact	Comment	Topic
Nancy Foster, American Hospital Association (cont.)	As the convener of the PAM, the NQF will have a fiduciary responsibility for the organization; however, we believe it is critical that the PAM be allowed as much autonomy as possible to conduct its work independent of the influence of the NQF's performance measurement activities. To that end, it will be critical for the PAM to have its own dedicated staff and resources, and the PAM should be able to determine its workplan and activities independent of ongoing NQF review and approval. While we agree that the initial rosters of the Patient-Focused Coordinating Committee (PFCC) and the workgroups should be appointed by the NQF board of directors, we believe that, once established, the PAM should autonomously appoint its own members without involvement of the NQF board. We also ask the NQF to articulate a policy regarding whether individuals are permitted to serve concurrently on both the NQF board and the PAM. Part of the process of ensuring PAM autonomy will be limiting the extent to which the same individuals are involved in leadership positions for both organizations.	General Comments
	The NQF proposal outlines the broad operating procedures for the PAM; however, we continue to experience some confusion about the relationship between the PFCC and the workgroups. The draft document states that the PFCC will have the authority to make recommendations on the PAM's behalf with the advice of the workgroups. This seems to mirror the NQF consensus development process whereby project steering committees make recommendations on performance measures with advice from technical expert panels (TEPs). In the past, there have been instances when steering committees have not followed the advice of a TEP, even when the TEP was in unanimous agreement about a quality measure. In the rare instances when this has occurred, NQF members representing different stakeholder positions have been understandably concerned with the NQF endorsement process. As a result, it has taken tremendous NQF staff resources and action by the Consensus Standards Approval Committee and the NQF Board to resolve these situations.	General Comments
	The AHA is concerned that without further guidance on the relationship between the PFCC and the workgroups, the PAM could struggle with some of the same issues that have befallen the consensus development process. Thus, we urge NQF to clearly articulate the roles and expectations of the PFCC and the workgroups and articulate a process that the PFCC must follow if it chooses not to follow the recommendations of a workgroup. Finally, we suggest that in a separate document, the NQF outline the step-by-step process through which the final recommendations would be made to HHS, including the roles and responsibilities of the PFCC and workgroups and how public comment would be solicited and incorporated into the recommendations. We suggest that NQF allow for public input not only when the PFCC has reached proposed recommendations, but also in the beginning of its deliberations. Just as NQF announces calls for measures in the consensus development process, the PFCC should issue calls to the public for measure suggestions for implementation for public reporting.	General Comments

Organization Contact	Comment	Topic
Nancy Foster, American Hospital Association (cont.)	The AHA requests more information from the NQF on the composition of the PFCC and the workgroups. We believe that representation on the PFCC and the workgroups should be balanced so that no particular stakeholder enjoys a majority representation. We also are seeking additional information from NQF on how many representatives will be seated at the PFCC and the workgroups at one time, how long each PAM representative's term will be, and whether representatives can serve multiple terms. The NQF proposes that representatives would not be allowed to send substitutes to meetings. The AHA believes that the recommendations and votes taken by the PAM will be viewed as more inclusive if appointees to the PAM have an opportunity to participate for each vote, regardless of whether they are physically able to attend a particular meeting. We urge NQF to remove the "no substitutions" policy from the proposed operating procedures. The Hospital Quality Alliance (HQA) has successfully allowed voting by proxy over the course of its deliberations, and HQA leaders would be happy to share their experiences and lessons learned with NQF staff. Again, we thank you for the opportunity to comment on the proposed organization of the PAM, and we look forward to continuing this dialogue as the PAM is further developed and established.	General Comments
Carolyn C. Zollar, J.D., American Medical Rehabilitation Providers Association *Additional information can be found in letter below	AMRPA appreciates the opportunity to review these documents. AMRPA applauds the foresight and preparatory work of NQF. We recommend that NQF ensure: 1.that the nomination process is open to the selection of any qualifying organization without restriction based upon alliance membership; 2.that every member organization is part of the overarching, final approval committee (ex: Coordinating Committee) to maintain the broad "multi- stakeholder" involvement throughout the process; and 3.that a member organization be allowed to appoint an alternative should the original representative be unable to attend or no longer be in a position to be the representative.	General Comments
	Under the ACA health reform legislation, a "multi-stakeholder group" is a "voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of quality measures." Thus, it is imperative that NQF allow public nominations from an unrestricted class of nominees. In other words, special solicitation of the NQF alliances for member nominations to serve as PAM members and provide input to the Secretary would represent only a select group of stakeholders and not be the broad group sought by the ACA.	Membership Responsibilities

Organization Contact	Comment	Topic
Carolyn C. Zollar, J.D., American Medical Rehabilitation Providers Association (cont.) *Additional information can be found in letter below	AMRPA is concerned this means that those members on the Coordinating Committee have to take the recommendations of the members of the Hospital Group, Clinical Group, or PAC/LT Group under advisement only. This creates two tiers of members. The first is members who make direct recommendations to the Secretary via the Coordinating Committee. The second is members who must first make recommendations to the Coordinating Committee, which then approves, amends or disapproves the recommendations before they reach the Secretary. Thus, those on the Coordinating Committee have complete authority to make recommendations.To ensure that the recommendations from PAM are from a "multi-stakeholder group" and not filtered through a smaller "Coordinating Committee" group, it would seem prudent that the Coordinating Committee be composed of all members. The advisory work groups should be a subset of the overall members on the Coordinating Committee. Thus, PAM members would all sit on the Coordinating Committee. Subgroups would be formed by a subset of PAM members who have expertise on hospitals, clinician, or PAC/LTC's.	Operational Procedures
	AMRPA suggests that PAM allow the appointment of a representative and an alternate for each member organization. The representative would be the main point of contact and representation at meetings. However, if there was a conflict and the representative could not attend, then the alternate would have the full authority to act in the role of the representative. It is reasonable to assume that the alternate would be fully informed, up to date, and consistently involved at the organizational level in the PAM work and tasks.	Operational Procedures
Rita Munley Gallagher, PhD, RN, American Nurses Association	As noted previously, the American Nurses Association (ANA), as the largest and most diverse nursing organization, has worked to convene the nursing community to provide input throughout the priority setting process and understands the level of detail inherent in the activity.	General Comments
	The American Nurses Association (ANA) offers the following additional input for consideration by the NQF Board of Directors as it moves forward to establish the Partnership: • The composition should allow for inclusion of the broadest level of subject matter expertise within the process	Membership Criteria
	The American Nurses Association (ANA) offers the following additional input for consideration by the NQF Board of Directors as it moves forward to establish the Partnership: • Utilization of organizational proxies has been successful in conducting the business of the Hospital Quality Alliance (HQA) Principals and should be allowed within the Partnership • Substitution for individual members, however, should not be permitted.	Operational Procedures

Organization Contact	Comment	Topic
Sarah Nicholls, American Physical Therapy Association *Additional information can be found in letter below	The use of quality measures can lead to improvement in patient care through appropriate translation of clinical evidence into practice, improved care processes and better coordination of services. Improved quality of care and care coordination can result in better health outcomes and cost savings. However, the development of quality measures should be a carefully structured process that includes appropriate stakeholders and is built upon a foundation of clinical evidence. The PAM is an opportunity to bring together these stakeholders and leverage their expertise. The proposed structure of an overarching Patient-Focused Coordinating Committee builds upon the unique knowledge base of clinicians in various health care settings including hospitals, post-acute care facilities, and independent clinicians. The needs of patients in these distinct health care settings will vary and quality measures specific to the patient populations in these settings is crucial. Additionally, NQF's plan to leverage the knowledge of organizations and individuals is critical to assembling the appropriate members of the workgroups and coordinating committee.	General Comments
	APTA encourages NQF to include the many stakeholders from various clinical backgrounds that are involved in treating the patient across the entire continuum of care in this initiative. APTA agrees that individual members should have expertise in quality measurement, public reporting, or performance-based payment. However, each of the groups, including the patient-centered coordinating committee, the hospital group, the clinician group and the PAC/LTC group, should be comprised of inter-professional and multi-disciplinary representation to offer a full spectrum of experiences and expertise to meet the intended goal.	Membership Criteria
	In its proposal, NQF states that candidates for membership will only be considered if they have the "ability to volunteer time and make resources available as necessary to accomplish the work of the Partnership, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on ad hoc groups." We would like to ensure that the expectation for support and resources is not inclusive of financial support or resources especially considering the federal funding made available for this purpose through the Accountable Care Act.	Membership Responsibilities
	A key policy decisions made by NQF in the developing the proposed structure of the PAM is to focus on transparency and accountability. Allowing for public nomination and comment on the selection of members may prevent members with a potential conflict of interest from impacting the ability of the PAM from effectively and efficiently develop measures that represent the best interests of patients. While we recognize the importance of consistent participation by PAM membership, requiring that those appointed to the PAM attend meetings and precluding them from appointing an alternate could impede the progress of its work. It is probable that a member of the PAM will have a scheduling conflict from time to time. Allowing them on occasion to send an alternate with knowledge of the PAM's work will allow this work to continue in an efficient manner. Finally, the development of processes to evaluate the work of the PAM and address concerns or complaints raised by the public ensure that the PAM will remain responsive to patient needs.	Operational Procedures

Organization Contact	Comment	Topic
Samantha Burch, Federation of American Hospitals	The Federation of American Hospitals (FAH) is pleased to have the opportunity to comment on the Proposed Member Selection Criteria, Member Responsibilities, and Operating Procedures for the Partnership for Applying Measures to Improve Quality (PAM). As you know, the FAH is a strong supporter of consultative process established in Section 3014 of the Affordable Care Act (ACA). The structure of the PAM, as proposed by the NQF Board, is a positive interpretation of that section of the Act, and we look forward to working with the PAM as it evolves over time.	General Comments
	The PAM is a two-tiered structure that includes the Patient-Focused Coordinating Committee and the Advisory Groups. The FAH notes that the Patient-Focused Coordinating Committee has the responsibility of forging consensus among the multi-stakeholders to be represented on the Committee. In our view, this is best achieved through clear and transparent processes, procedures and open communication. The FAH recommends that the operational documents be very explicit that one or two members of each advisory group will be members of the Patient-Focused Coordinating Committee in order to facilitate the cross-fertilization and consensus-driven decisions that will be necessary.	Membership Criteria
	The FAH also strongly supports the member criterion stating that those at the table have demonstrated a commitment to forging consensus and reaching agreement. The recommendations from the PAM will greatly influence the work of the HHS Secretary in selecting measures for public reporting, and that process is often extremely complex and challenging.	Membership Criteria
	As noted in prior comments, the PAM will evolve overtime. However, thought should be given at the outset to the length of terms and the staggering of terms to ensure continuity of members, work, and stakeholder perspectives. Also, procedures should contemplate the possibility that research may be needed as the process evolves. The FAH would assume that outside experts could be contracted with to assist with this analytical work, but would not necessarily be seated with a vote at either the Advisory Group or Coordinating Committee level.	Operational Procedures
	The "recommendations" bullet under the proposed operating procedures section states that the Coordinating Committee will authority to make recommendations falls within the purview of the Partnership's charge, but it is unclear how that authority would be executed. The FAH recommends that the operating procedures be explicit in defining that the role of the Coordinating Committee be one that works through differences and develops consensus should conflicting recommendations come forward from the Advisory Groups. One could foresee a situation where different Advisory Groups looking at proposed measures from different vantage points may disagree, offering conflicting advice to the Coordinating Committee. The Coordinating Committee, with explicit representation of advisory groups already in its member criteria, should seek further input from the advisory groups to as necessary.	Operational Procedures

Organization Contact	Comment	Topic
Samantha Burch, Federation of American Hospitals (cont.)	The FAH strongly recommends that some provision be made to permit proxy voting and/or substitutes to sit-in for principals in certain circumstances. The assumption would be that the principals (appointed person) would be at the table unless extreme circumstances prevail, but given our complex world and the important nature of the work of the PAM, the principal may not always be able to be present. In that case, the FAH suggests that proxy voting/representation be permitted to preserve the input of that stakeholder in the process.	Operational Procedures
Gaye Fortner, HC21	I believe prioritizing membership entities limits potentially qualified organizations that can achieve this goal. I recommend the criteria be revised to say "organizations should be entities that represent leading stakeholder groups affected by the use of quality measures." I support appointing individual subject matter experts to the PAMIQ. These individuals can be appointed in a way that will not create an imbalance in the multi-stakeholder composition of the body.	Membership Criteria
	I feel that the PAMIQ should allow for representatives to send a proxy in the event that the designated rep cannot attend a PAMIQ meeting. Under the operating procedures, there should be a process designed to allow reps to designate proxies, as well as a process for making the proper notifications that a proxy will be in attendance. Having this policy in place will ensure that all stakeholders' voices are heard throughout the process. One of the responsibilities outlined in the document is "ability to volunteer time and make resources available as necessary to accomplish the work of the Partnership…" I perceive this call to "make resources available as necessary" to refer to human resources; in other words, members will be expected to be available to conduct the work of the Partnership outside of the time spent convening. However, it would be helpful to have clarification on this point to ensure that members are not being asked to provide financial resources. Given the importance of ensuring a diversity of perspectives, NQF must consider a strategy for providing technical support, when appropriate, for members of the coordinating council and the sub-groups to ensure full participation by all members in the deliberation and consensus-building process. The dialogue around quality and performance measures can become very technical, and we should ensure that members of the PAMIQ have the tools they need to appropriately represent their constituents' interests.	Membership Responsibilities
	I would appreciate clarification on how the Patient-Focused Coordinating Council (PFCC) will interact with the provider sub-groups. The report states that members of the provider groups (hospital, physician, and PAC/LTC) will not be able to make recommendations, but will only be able to advise the PFCC. I would also like clarification on what the process will be for the provider sub-groups to advise the PFCC, and how will situations be resolved when there is not a consensus between the PFCC and the subgroup's advisories. Will there be communication between the three sub-groups, or will all communications flow from the individual sub-group up to the PFCC? The operating procedures call for a simple majority vote by the PFCC to pass a motion. I would like clarification on whether this meets the standards set by the National Technology Transfer and Advancement Act of 1995, which set the requirements for the federal government using private industry consensus standards.	Operational Procedures

Organization Contact	Comment	Topic
John Sakowski, Institute for Clinical Systems Improvement	ICSI endorses the proposed criterion on page 4 requiring that organizational members of the Partnership for Applying Measures have involvement and experience in quality measurement and reporting, but we would urge that the criterion be expanded to explicitly give preference to regional multi-stakeholder collaboratives which are currently doing public reporting of quality measures (such as the organizations which are members of the Network for Regional Healthcare Improvement). We would also urge that the criteria on page 3 be expanded to require that some members of the Partnership be state and regional multi-stakeholder organizations, such as Regional Health Improvement Collaboratives, not just single-stakeholder membership groups.	Membership Criteria
Dolores Yanagihara, Integrated Healthcare Association	The Integrated Healthcare Association (IHA) endorses the proposed criterion on page 4 requiring that organizational members of the Partnership for Applying Measures have involvement and experience in quality measurement and reporting, but we urge that the criterion be expanded to explicitly give preference to multi-stakeholder collaboratives, such as the organizations that are members of the Network for Regional Healthcare Improvement. These organizations, by the nature of their activities and composition, have expertise in quality measurement and reporting, and generally represent a balance of stakeholder interests. We also urge that the criteria on page 3 be expanded to require that some members of the Partnership be state and regional multi-stakeholder organizations, not just single-stakeholder membership groups. Thank you.	Membership Criteria
Diane Mayberry, MN Community Measurement	MNCM endorses the proposed criterion on page 4 requiring that organizational members of the Partnership for Applying Measures have involvement and experience in quality measurement and reporting, but we would urge that the criterion be expanded to explicitly give preference to regional multi-stakeholder collaboratives which are currently doing public reporting of quality measures (such as the organizations which are members of the Network for Regional Healthcare Improvement). We would also urge that the criteria on page 3 be expanded to require that some members of the Partnership be state and regional multi-stakeholder organizations, such as Regional Health Improvement Collaboratives, not just single-stakeholder membership groups. Thanks, MNCM	Membership Criteria
Ellen Schwalenstocker, NACHRI	The National Association of Children's Hospitals and Related Institutions (NACHRI) is pleased to have the opportunity to comment on the proposed member selection criteria, member responsibilities and operating procedures. We appreciate, and strongly support, the inclusion of the need for representation of lifestages (including children) in the membership.	Membership Criteria

Organization Contact	Comment	Topic
Debra Ness, National Partnership for Women & Families	We have two comments on the proposed membership criteria. first, the report states that "organizations selected for the Partnership should be membership entities that represent leading stakeholder groups affected by the use of quality measures." The goal for the PAMIQ is to ensure broad stakeholder representation. We are concerned that saying that the entities must specifically be "membership" entities could become a barrier to participation of some organizations because of the broad range of definitions organizations use to define their constituents. We therefore recommend that the criteria be revised to simply say "organizations should be entities that represent leading stakeholder groups affected by the use of quality measures." Second, we support appointing individual subject matter experts to the PAMIQ. However, just as with organizational representatives, these individuals should represent an appropriate balance of perspectives.	Membership Criteria
	We have three comments regarding membership responsibilities: First, we believe that the current provisions that do not allow participation or voting by proxy are too rigid. We understand the intent but urge NQF to create a process with sufficient flexibility to ensure that with adequate advance notification organizations can ensure that their stakeholder voices are heard even if for some reason their appointed representative cannot attend a particular meeting. Having a more flexible process will help ensure that all stakeholders' voices are heard throughout the process. Second, one of the responsibilities outlined in the document is "ability to volunteer time and make resources available as necessary to accomplish the work of the Partnership…" We believe the intent here is to ensure that members are willing to dedicate the appropriate time, personal resources, and organizational expertise needed to facilitate the work of the PAMIQ—including at times providing appropriate support and involvement in activities that may occur outside the formally convened meetings. However, it would be helpful to have clarification on this point to ensure that members are not being asked to provide financial resources, and that financial resources or capacity will not be a factor in selection of members.	Membership Responsibilities
	Third, given the importance of ensuring a diversity of perspectives, NQF should consider a strategy for providing technical support, as appropriate, for members who may have varying levels of technical expertise. This is essential to ensure that all stakeholders are able to engage equally and collaboratively on a level playing field. The dialogue surrounding quality measurement can be highly technical and specialized at times and we want to ensure that all members of the PAMIQ (especially consumers and purchasers) have the tools they need to appropriately represent their constituents' interests.	Membership Responsibilities

Organization Contact	Comment	Topic
Debra Ness, National Partnership for Women & Families (cont.)	We would appreciate further clarification on how the Patient-Focused Coordinating Council (PFCC) will interact with the advisory workgroups. The report states that members of the advisory workgroups will advise the PFCC and the PFCC will make recommendations to HHS. Further clarification of this process would be helpful especially for situations when there is not consensus between the PFCC and workgroups. It would also be useful to clarify the process for communication between workgroupsFinally, the operating procedures call for a simple majority vote by the PFCC to pass a motion. We seek clarification on whether this meets the standards set by the National Technology Transfer and Advancement Act of 1995, which set the requirements for the federal government using private industry consensus standards. There may be segments of the PAMIQ process that should require a consensus versus a simple majority, and we believe that further discussion in this area is very important.	Operational Procedures
Sarah Thomas, NCQA	Ideally, the PAM will be a useful resource for policymakers and program evaluators, who would be able to consult PAM analysis and recommendations for careful and thoughtful consideration of measures and aspects of study design and implementation affecting measurement in pay for performance and other quality and payment initiatives. The PAM should regularly invite presentations and analysis from a wide variety of collaborative activities to learn from the success or failure – and review not only measures but other elements of program implementation. We would expect other governmental and research organizations to also conduct this type of program development and evaluation, but the PAM can serve as a significant clearinghouse for lessons learned and most recent knowledge.	General Comments
	Proposed Member Selection Criteria, Member Responsibilities, and Operating Procedures: Partnership for Applying Measures to Improve Quality (PAM) Thank you for the opportunity to comment on the proposed procedures and other details concerning membership. Within a multitier structure, the NQF procedures would provide for two types of members – organizational members consisting of membership organizations and individual members, with the larger part of the PAM consisting of organizational members. NCQA recommends that NQF reconsider its decision to divide members of the different parts of the PAM into these two categories (with preference to membership organizations). Instead, we recommend that each tier of the PAM include a balance of organizations and individuals with relevant experience and expertise in quality measurement, economics and program evaluation as well as from industry groups to which the measures to which the measures apply. The overall composition of the group should represent many stakeholders, but each member should not be held to representing interests. The current proposal for the membership structure runs the risk of having most members narrowly focused on specific membership interests, rather than achieving a balance of good scientific and policy recommendations.	Membership Criteria

Organization Contact	Comment	Topic
Sarah Thomas, NCQA (cont.)	NCQA supports other aspects of the procedures – it is particularly useful to list expectations and responsibilities for members -- and the operational procedures are sound.	Operational Procedures
Harold Miller, Network for Regional Healthcare Improvement	We urge that the first criterion on page 3 be modified to read "Organizations selected for the partnership should include (a) membership entities that represent leading stakeholder groups affected by the use of quality measures, and (b) multi-stakeholder collaboratives that operate programs to publicly report provider performance on quality measures or to improve provider performance on quality measures." We believe it is important that the Partnership not just be composed of single-stakeholder membership groups, but also include organizations such as Regional Health Improvement Collaboratives that have experience in forging consensus among multiple stakeholder organizations on quality improvement initiatives.	Membership Criteria
	We endorse the first criterion on page 4 requiring that organizational members of the Partnership for Applying Measures have involvement and experience in quality measurement and reporting, but we would urge that the criterion be expanded to explicitly give preference to regional multi-stakeholder collaboratives which are currently doing public reporting of quality measures (such as the organizations which are members of the Network for Regional Healthcare Improvement). This could be accomplished by adding the following sentence: "At least some of the organizational members should include multi-stakeholder regional health improvement collaboratives which are currently doing public reporting of quality measures."	Membership Criteria
Christine Chen, Pacific Business Group on Health	The report states that "organizations selected for the Partnership should be membership entities that represent leading stakeholder groups affected by the use of quality measures." Having organizations that truly represent their stakeholder constituencies is the goal for PAMIQ. We believe limiting selection to membership entities does not permit participation of potentially qualified organizations that can achieve this goal. We recommend that the criteria be revised to "organizations should be entities that represent leading stakeholder groups affected by the use of quality measures." We support appointing individual subject matter experts to the PAMIQ, and these individuals can be appointed in a way that will not create an imbalance in the multi-stakeholder composition of the body.	Membership Criteria
	We feel that the PAMIQ should allow for representatives to send a proxy in the event that the designated representative cannot attend a PAMIQ meeting. Under the operating procedures, there should be a process designed to allow representatives to designate proxies. Having this policy in place will ensure that all stakeholders' voices are heard throughout the process. Given the importance of ensuring a diversity of perspectives, NQF must consider a strategy for providing technical support – when appropriate – for members of the coordinating council and the sub-groups, to ensure full participation by all members in the deliberation and consensus-building process. The dialogue around quality and performance measures can become very technical, and we want to ensure that members of the PAMIQ have the tools they need to appropriately represent their constituents' interests.	Membership Responsibilities

Organization Contact	Comment	Topic
Christine Chen, Pacific Business Group on Health (cont.)	We would appreciate further clarification on how the Patient-Focused Coordinating Council (PFCC) will interact with the provider sub-groups. The report states that members of the provider groups (hospital, physician, and PAC/LTC) will not be able to make recommendations, but will only be able to advise the PFCC. It is unclear what that means in practical terms. In addition, we seek clarification on what the process will be for the provider sub-groups to advise the PFCC, and how will situations be resolved when there is not consensus between the PFCC and the subgroup's advisories. Moreover, will there be communication between the three sub-groups, or will all communications flow from the individual sub-group up to the PFCC? A diagram or flow-chart that details how the process of communicating advice and recommendations among the groups and to the Secretary would be very helpful.The operating procedures call for a simple majority vote by the PFCC to pass a motion. We seek clarification on whether this meets the standards set by the National Technology Transfer and Advancement Act of 1995, which set the requirements for the federal government using private industry consensus standards. There may be segments of the PAMIQ process that should require a consensus versus a simple majority, and more clarification on this is requested.	Operational Procedures
Mark Keroack, University HealthSystem Consortium	We support the criteria of multistakeholder groups affected by quality measurement, as well as the emphasis on those with a track record of quality measurement and reporting. We would urge that additional consideration be given to organizations with a track record of using measurement to improve the performance of multistakeholder groups in quality, safety or cost effectiveness. The ultimate goal of measurement and reporting is implementing improvements, and the latter is a distinct competency that should be reflected at the level of the coordinating committe. Organizations with this competency will bring to the table expertise in practical approaches to data collection and overcoming barriers to implementation.	Membership Criteria

AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

August 18, 2010

Janet Corrigan, MBA, PhD
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Washington, DC 20005

Dear Dr. Corrigan,

On behalf of the American Academy of Family Physicians (AAFP), an organization that represents over 94,700 physicians and medical students nationwide, I write to offer comments to the National Quality Forum's (NQF) proposed member selection criteria, member responsibilities, and operating procedures for the Partnership for Applying Measures to Improve Quality (PAM). The Academy appreciates NQF's proactive approach to solicit public input regarding the potential new responsibilities that NQF could assume if NQF is assigned the additional task of serving as a neutral convener, as outlined in Sec. 3014 of the Affordable Care Act (ACA). I urge the NQF to consider these comments to help inform deliberations of the PAM Nominating Committee that will propose the PAM membership criteria and responsibilities to the whole NQF Board of Directors at its September 23, 2010 meeting.

Member Selection Criteria

AAFP remains supportive of NQF and the outreach exhibited through this supplementary comment opportunity. However AAFP must also request further explanation on the proposed member selection criteria and sequencing of the nominating process. Specifically, it must be clarified whether the NQF board will choose the multi-stakeholder groups before or after a public comment opportunity. In addition, AAFP urges NQF to further specify the specific roles, responsibilities, and timing deadlines of a nominating committee as well as what opportunities the public will have to provide additional input to the process.

Since Sec. 3014 specifically calls for convening a multi-stakeholder group, AAFP above all advocates for the Patient-Focused Coordinating Committee and other workgroups to be balanced in representation so that no single industry group unfairly enjoys a majority. Doing so will ensure that all participating groups trust, get a fair assessment, and fully understand how quality and efficiency measures generated by the PAM will eventually impact the quality of care to their members.

Furthermore, NQF should define more precisely the term "leading stakeholder groups" so that interested parties are fully aware of all aspects before applying for membership. The NQF needs to specify whether a group's size, longevity, size and/or type of membership, etc. will eventually guide the NQF to eventually deem which organizations are or are not labeled "leading stakeholder groups".

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Member Responsibilities

Involvement in quality improvement initiatives already requires patient and provider organizations to commit staff time to accomplish important coalition goals. In order to convene as diverse a range of multi-stakeholders as possible, AAFP urges NQF to clarify that PAM participation does not require any financial commitments and/or member dues. Since the Affordable Care Act already funds these quality improvement activities, NQF should clearly state this in the finalized member responsibility information made available for prospective participants.

Similar to comments made concerning the need for a diverse and transparent Patient-Focused Coordinating Committee, I also urge NQF to clarify that the NQF Board, in its selection of chair and vice-chair for the coordinating committee and workgroups, must also appoint from a diverse range of stakeholders. Doing so would both prevent biases from any single interest group and facilitate the goal of creating a consensus based entity to promote the development of quality and efficiency measures.

Operating Procedures

Scheduling conflicts should not bar participation in this important consensus based process. AAFP opposes the NQF plan to not allow organizational representatives to send substitutes or allow proxy voting at future meetings. Since NQF's intended goal is to convene "leading stakeholder groups", these leaders will consistently encounter conflicts that prevent or limit participation from attending all meetings. When these conflicts occur, voting by proxy through a well-informed and chosen staff person must be allowed.

As always, the AAFP looks forward to working with NQF in its continued efforts to study and improve the quality of physician services.

Sincerely,

Ted Epperly MD

Ted D. Epperly, MD, FAAFP
Board Chair

The following is a comment submitted via email on August 18, 2010:

We appreciate the opportunity to comment and believe that the structure and process outlined are reasonable to achieve the statutory purpose of the Partnership for Applying Measures (PAM). We are concerned, however, that the proposed participation criteria rely too much on membership-based organizations. Clearly, NQF's statutory authority entails the assurance of broad stakeholder representation, and membership organizations by definition deliver this. However, membership organizations do not represent the universe of organizations with a significant, legitimate stake in the selection/use of a national set of quality measures, or those that have substantial expertise in developing/deploying quality measures in practice.

For example, public-facing specialty certifying and accrediting organizations have a direct interest in assuring the evolution and application of scientifically grounded, clinically relevant quality measures. They also have deep knowledge of and experience with the technical aspects of performance assessment, and well-validated methods for developing and deploying evidence-based measurement and assessment tools. Yet because they are not membership organizations, they would, under the proposed criteria, be excluded from PAM participation. In short, we believe that by limiting participation to "membership" organizations, the Partnership will not be able to fulfill its mandate to assure broad representation of stakeholder interest, and also will forgo important input into the development, analysis and prioritization of its metrics in support of a National Quality Strategy. For these reasons, we recommend that you remove that requirement from the PAM membership selection criteria.

Ann C. Greiner
Vice President of Policy
American Board of Internal Medicine

American Health Care Association

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August 17, 2010

Janet M. Corrigan, PhD, MBA
President and CEO
National Quality Forum
601 Thirteenth Street, NW
Washington, DC 20005

Dear Dr. Corrigan:

On behalf of the American Health Care Association, we appreciate the opportunity to comment on the proposed member selection, responsibility and operating procedures for the Partnership for Applying Measures to Improve Quality. We support the need for a multi-stakeholder entity to report to the Secretary of Health and Human Services on quality measures for specific care settings and for payment programs like bundling. This important project will impact long term care service delivery. For this reason I urge you to include long term care representatives in both the PAM Hospital and Clinical groups that report to the Patient Focused Coordinating Committee.

Listed below are other items which should be addressed as the measures are assessed:

- Most measures developed for quality improvement and reporting by National Quality Forum have not been designed for payment purposes. It is not clear whether the proposed committee will be considering new measures specifically developed with payment in mind, or if existing measures will be evaluated for payment purposes. If existing measures are considered, additional work is needed that provides evidence of the measure as reliable, accurate and valid enough to perform for payment purposes.
- Measures need to encompass outcomes related to individuals with multiple chronic conditions (MCC). The comments from The Geriatric Society, June 15, 2010, identified the need to "account for co-morbidities like cognitive status, assistance with daily living impairment, and pain." The measures need to go further to address people that have several or all of the co-morbid conditions. Current measures lack adequate risk adjustment to reliably, accurately, and validly measure outcomes in this population. This concern is supported by the HHS Initiative on MCCs that identifies that limited research has yielded information about most prevalent subgroups of individuals with MCCs, but additional research is needed identifying the most common patterns of MCC.
- Measures used for payment purposes, like bundling, need to be standardized across all settings of care where the measures apply. This requires a common definition and set of data sources from which the measures are based. The CARE tool may be a start to standardize measurement system but the tool is still in development and not yet approved for national implementation.
- Long term care providers need to be represented from the outset of the coordinating committee's work as the measures for hospital and clinicians as many individual are cared by these providers.

Thank you for the opportunity to comment on this important endeavor.

Sincerely,

Bruce Yarwood
President and CEO

August 18, 2010

Janet Corrigan, MBA, PhD
President and Chief Executive Officer
National Quality Forum
601 13th Street NW, Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan,

The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) proposed member selection criteria, member responsibilities, and operating procedures for the *Partnership for Applying Measures to Improve Quality* (PAM). We note that Attachment B of the proposal regarding comments to the establishment of PAM was helpful, and encourage that a similar summary be developed for the current Partnership criteria proposal.

The AMA has long been and continues to be committed to the development of quality improvement initiatives that enhance the quality of care provided to patients. It is from this perspective that we offer the following comments on proposed member selection criteria, member responsibilities, and operating procedures of the Partnership.

Public Input
It is disappointing that the NQF only received twenty-two public comments. In an effort to promote public engagement regarding development of the Partnership, NQF may want to consider spotlighting Partnership proposal activities to all NQF member organizations. These activities could include distribution of standalone Partnership related emails, as well as hosting educational webinars regarding Sec. 3014 of the Affordable Care Act. Highlighting the interconnectivity between Sec. 3014 and NQF activities around the development and identification of operational criteria for the new Partnership may improve overall public engagement.

Stakeholder's Interests and Membership Criteria
The AMA supports the important role of the NQF board, a nominating committee and the public in shaping the roster of organizations and individuals that will participate in PAM. However, we welcome further clarification of the nominating process. AMA understands the NQF board will select the multi-stakeholder groups under each tier of the Partnership after a call for nominations. We ask NQF to clarify if this will occur after public comment or before. Further, we urge NQF to articulate the role and responsibilities of the nominating committee and to identify at what point(s) they will be providing input to the process. Moreover, in an effort to better understand

the direction of the PAM, the AMA seeks further articulation of the final composition of PAM, and whether composition will reflect current NQF membership sectors.

Second, in light of the important role of the Patient Coordinating Committee, AMA recommends that the composition of both the Coordinating Committee as well as the workgroups have balanced representation with no one group or interest having a majority of seats. The overlap between the workgroups and the Coordinating Committee will ensure appropriate representation of each group's perspective and foster communication and collaboration between and among the groups.

Finally, the proposed criteria for selecting PAM organizations state, "Organizations selected for the Partnership should be membership entities that represent leading stakeholder groups affected by the use of quality measures." Before commencement of the Partnership nominating process, NQF should clearly outline what is meant by "leading" stakeholder group e.g., size and diversity of membership, years of operation, support and involvement from provider community etc. Without clarification, stakeholder groups interested in applying for membership may be misled.

PAM Member Responsibilities

The proposal outlines that the "ability to volunteer time and make resources available as necessary to accomplish the work of the Partnership, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on ad hoc groups" will be considered a responsibility for a PAM member. The AMA urges that membership responsibility in the Partnership not include a commitment to provide financial resources. This should be clearly stated in the final list of member responsibility criteria. The Affordable Care Act clearly provides that funding is authorized to be appropriated for these activities, and the Secretary of Health and Human Services will distribute a portion of these monies to NQF for convening and managing the Partnership.

The proposal also states that the "NQF Board will select a chair and vice-chair from among the [PAM] members for the Patient-Focused Coordinating Committee and each work group." The AMA urges that the NQF Board select chairs and vice-chairs representing a variety of stakeholder groups e.g., a provider, a consumer, and purchaser group. Ensuring a chair and vice-chair represent different stakeholder groups will help promote balanced evaluation and deliberation.

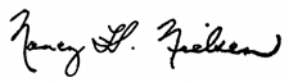
Operating Procedures

The proposal outlines several operating procedures for the Partnership, which includes decision-making. It states, "A simple majority of voting members of the Patient-Focused Coordinating Committee in attendance will be required to pass a motion." It goes on to say, "organizational representatives and individuals selected for membership will not be allowed to send substitutes to meetings." As mentioned above, NQF proposes that Partnership members be comprised of "leading" stakeholder groups affected by the use of quality measures. Organizational representatives of these "leading" organizations will inevitably have conflicts that prevent them from participating in a Partnership call or meeting. If this happens, a Partnership member should

be permitted to: (1) vote by proxy through designated staff; or (2) send a substitute who is knowledgeable about Partnership issues. The inability of a specific organizational representative to participate and/or attend should not preclude a particular stakeholder group from voting or having its voice heard.

We appreciate your consideration of our comments and look forward to working with NQF and other stakeholders on developing a transparent, diverse, and effective Partnership that streamlines and strengthens the use of quality measures within our nation's health care system.

Sincerely,



Nancy H. Nielsen M.D., PhD

American Medical Rehabilitation Providers Association

Bruce M. Gans, M.D.
Executive Vice President and Chief Medical Officer
Kessler Institute for Rehabilitation
AMRPA Chairman of the Board

August 17, 2010

Janet Corrigan, Ph.D.
Executive Director
National Quality Forum
601 13th Street, NW, S. 500 North
Washington, DC 20005

Delivered Electronically

Re: *Call for Comments: Proposed Member Selection Criteria, Member Responsibilities, and Operating Procedures for Public Comment, July 16, 2010*

Dear Dr. Corrigan:

This letter is submitted on behalf of the American Medical Rehabilitation Association (AMRPA). AMRPA is the national trade association which represents over 500 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers. Most, if not all, of our members are Medicare participating providers. Inpatient rehabilitation hospitals and units (IRH/Us) serve approximately 400,000 Medicare beneficiaries per year. Medicare Part A payments represent, on average, over 60% of their revenues. AMRPA members work with patients to maximize health, functional skills, independence, and participation in society so they are able to return to home, work, and/ or an active retirement. The recommendations for new quality measures that the National Quality Forum's (NQF) Partnership for Applying Measures to Improve Quality (PAM) provides to the Secretary of Health and Human Services (HHS) will have dramatic implications for our members. We appreciate the opportunity to review and comment on the proposed Partnership and its methods of membership selection.

We commend NQF for taking the steps to prepare for its potential responsibility with the goal of obtaining broad stakeholder involvement to provide input on measure selection for public reporting and payment programs. We have reviewed the above captioned Call for Comments and our comments follow. We understand these comments will aid the NQF Board in its deliberations on September 23, 2010.

I. Background

Under the health reform legislation, the Patient Protection and Affordable Care Act (PPACA)[1], new duties are assigned to the consensus-based entity. Among these duties is the responsibility for convening multi-stakeholder groups to provide input to the Secretary of HHS on the selection of quality measures for public reporting and payment programs. If NQF is tasked with carrying out this consultative process as a neutral convener, this will clearly be an extensive and important role for it in the reporting of quality data.

In response to the NQF paper entitled, *Establishment of a Partnership for Applying Measures to Improve Quality*[2], AMRPA asked for clarification about how nominations for members and selection of members would occur. We were concerned that PAM membership would be restricted to those who are already members of the NQF Alliance. In turn, we were concerned that PAM would not adequately represent and examine the needs of medical rehabilitation patients and providers.

II. Member Selection Criteria

Under the ACA health reform legislation, a "multi-stakeholder group" is a "voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of quality measures."[3] Thus, it is imperative that NQF allow public nominations from an unrestricted class of nominees. In other words, special solicitation of the NQF alliances for member nominations to serve as PAM members and provide input to the Secretary would represent only a select group of stakeholders and not be the broad group sought by the ACA.

For example, given that AMRPA is the sole organization representing exclusively the concerns of rehabilitation providers including Inpatient Rehabilitation Hospitals and Units (IRH/Us) and their patients, AMRPA's inclusion in the nominations and comment processes would be a clear voice on behalf of IRH/Us, their Medicare patients, and other patients. While we commend NQF for building upon the work of the AQA Alliance (AQA), the Hospital Quality Alliance (HQA), and the Pharmacy Quality Alliance (PQA), inpatient rehabilitation hospitals and units and their Medicare patients do not have representation on these alliances. AMRPA's concern is that by only accepting nominations and feedback for PAM from the aforementioned alliances, to the exclusion of others, the field of advice and expertise will be narrow.

III. Operating Procedures

AMRPA particularly applauds NQF for making openness and transparency part of its operating procedures. Transparency will certainly enhance effectiveness of partnership and the overarching effort.

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[1] P.L. 111-148

[2] NQF, *Establishment of a Partnership for Applying Measures to Improve Quality: to Provide Input on Measure Selection for Public Reporting and Payment Programs*, May 10, 2010, at 3, *available at* http://www.cpehn.org/pdfs/Establishment%20of%20a%20Partnership%20-%20NQF.pdf.

[3] HR 3590 §3014(a)(1), amending SSA §1890(b) by adding (7)(D).

A. Recommendations

In terms of "recommendations" the proposed operating procedure states:

"The Patient-Focused Coordinating Committee will have the authority to make recommendations falling within the purview of the Partnership's charge. The work groups will not make recommendations, rather they will advise the Coordinating Committee. Partnership recommendations are not subject to approval or ratification by the NQF Board."[4]

AMRPA is concerned this means that those members on the Coordinating Committee have to take the recommendations of the members of the Hospital Group, Clinical Group, or PAC/LT Group under advisement only. This creates two tiers of members. The first is members who make direct recommendations to the Secretary via the Coordinating Committee. The second is members who must first make recommendations to the Coordinating Committee, which then approves, amends or disapproves the recommendations before they reach the Secretary. Thus, those on the Coordinating Committee have complete authority to make recommendations.

To ensure that the recommendations from PAM are from a "multi-stakeholder group" and not filtered through a smaller "Coordinating Committee" group, it would seem prudent that the Coordinating Committee be composed of all members. The advisory work groups should be a subset of the overall members on the Coordinating Committee. Thus, PAM members would all sit on the Coordinating Committee. Subgroups would be formed by a subset of PAM members who have expertise on hospitals, clinician, or PAC/LTC's.

AMRPA would like to reinforce a statement from our prior comment letter. Organizations representing IRH/Us, such as AMRPA, would be able to play a valuable role in the Hospital and PAC/LTC Groups. Such involvement would be appropriate if the definition of post acute care for this group includes rehabilitation hospitals, long term care hospitals, and other downstream post acute care providers who receive referrals from acute care hospitals, long term care hospitals, or inpatient rehabilitation hospitals.

B. No substitutes

The proposed "operating procedures" state: "Organizational representatives and individuals selected for membership will not be allowed to send substitutes to meetings"[5]. It would seem that NQF's rationale might be to maintain a consistent voice on behalf of each PAM member organization. However, it would be unrealistic to imagine that an organizational representative might be able to appear at each and every meeting. Because organizations, of the caliber and expertise as would be selected for membership, have more than one qualified representative who has expertise, insight, and dedication to the task at hand, AMRPA suggests that this "no substitute" rule be modified.

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[4] NQF, *Partnership for Applying Measures to Improve Quality: Proposed Member Selection Criteria, member Responsibilities, and Operating Procedures for Public Comment.* July, 16, 2010, at 5, *available at* http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=30174.

[5] *Id.*

AMRPA suggests that PAM allow the appointment of a representative and an alternate for each member organization. The representative would be the main point of contact and representation at meetings. However, if there was a conflict and the representative could not attend, then the alternate would have the full authority to act in the role of the representative. It is reasonable to assume that the alternate would be fully informed, up to date, and consistently involved at the organizational level in the PAM work and tasks.

IV. Summary

AMRPA appreciates the opportunity to review these documents. AMRPA applauds the foresight and preparatory work of NQF. We recommend that NQF ensure:

1. that the nomination process is open to the selection of any qualifying organization without restriction based upon alliance membership;
2. that every member organization is part of the overarching, final approval committee (ex: Coordinating Committee) to maintain the broad "multi- stakeholder" involvement throughout the process; and
3. that a member organization be allowed to appoint an alternative should the original representative be unable to attend or no longer be in a position to be the representative.

If you have any questions, please feel free to contact me or Carolyn Zollar at AMRPA (czollar@amrpa.org).

Sincerely,

Bruce M. Gans, M.D.
Executive Vice President and Chief Medical Officer
Kessler Institute for Rehabilitation
AMRPA, Chairman of the Board

cc Carolyn Zollar
AMRPA Board of Directors
Martha Kendrick

American Physical Therapy Association

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Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

August 18, 2010

Janet Corrigan
National Quality Forum
601 13th St, NW
Suite 500 North
Washington, DC 20005

Dear Ms. Corrigan:

On behalf of our 74,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the proposed member selection criteria, member responsibilities, and operating procedures of the Partnership for Applying Measures to Improve Quality (PAM). APTA has been extensively involved with the development of quality measures to be reported by physical therapists. We are committed to developing quality measures that provide opportunities to improve patient care and care coordination among members of the health care team. We support NQFs' goal to improve the quality of health care and applaud your efforts to further clarify and seek comment on the selection criteria and related procedures because we believe it supports the goals we have articulated for the development and use of quality measures.

Structure of the PAM

The use of quality measures can lead to improvement in patient care through appropriate translation of clinical evidence into practice, improved care processes and better coordination of services. Improved quality of care and care coordination can result in better health outcomes and cost savings. However, the development of quality measures should be a carefully structured process that includes appropriate stakeholders and is built upon a foundation of clinical evidence. The PAM is an opportunity to bring together these stakeholders and leverage their expertise. The proposed structure of an overarching Patient-Focused Coordinating Committee builds upon the unique knowledge base of clinicians in various health care settings including hospitals, post-acute care facilities, and independent clinicians. The needs of patients in these distinct health care settings will vary and quality measures specific to the patient populations in these settings is crucial. Additionally, NQF's plan to leverage the knowledge of organizations and individuals is critical to assembling the appropriate members of the workgroups and coordinating committee.

Member Selection Criteria

APTA encourages NQF to include the many stakeholders from various clinical backgrounds that are involved in treating the patient across the entire continuum of care in this initiative. APTA agrees that individual members should have expertise in quality measurement, public reporting, or performance-based payment. However, each of the groups, including the patient-centered coordinating committee, the hospital group, the clinician group and the PAC/LTC group, should be comprised of inter-professional and multi-disciplinary representation to offer a full spectrum of experiences and expertise to meet the intended goal.

Member Responsibilities

In its proposal, NQF states that candidates for membership will only be considered if they have the "ability to volunteer time and make resources available as necessary to accomplish the work of the Partnership, including meeting preparation, attendance and active participation at meetings, completion of assignments, and service on ad

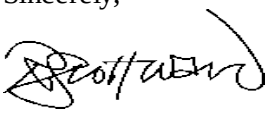
hoc groups." We would like to ensure that the expectation for support and resources is not inclusive of financial support or resources especially considering the federal funding made available for this purpose through the Accountable Care Act.

Operating Procedures

A key policy decisions made by NQF in the developing the proposed structure of the PAM is to focus on transparency and accountability. Allowing for public nomination and comment on the selection of members may prevent members with a potential conflict of interest from impacting the ability of the PAM from effectively and efficiently develop measures that represent the best interests of patients. While we recognize the importance of consistent participation by PAM membership, requiring that those appointed to the PAM attend meetings and precluding them from appointing an alternate could impede the progress of its work. It is probable that a member of the PAM will have a scheduling conflict from time to time. Allowing them on occasion to send an alternate with knowledge of the PAM's work will allow this work to continue in an efficient manner. Finally, the development of processes to evaluate the work of the PAM and address concerns or complaints raised by the public ensure that the PAM will remain responsive to patient needs.

In conclusion, we appreciate NQF's efforts to implement the requirements of the Accountable Care Act. We look forward to working with NQF to ensure the needs of patients served by physical therapists are met through the development of quality measures. If you have any questions, please contact Sarah Nicholls, Assistant Director for Payment Policy and Advocacy, at sarahnicholls@apta.org or 703-706-3189.

Sincerely,



R Scott Ward, PT, PhD
President

RSW:sn

August 20, 2010

Janet Corrigan, PhD, MBA
President & CEO
National Quality Forum
601 Thirteenth Street, NW Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan,

On behalf of the AQA Steering Group, we appreciate the opportunity to provide further comment on the National Quality Forum's (NQF) Establishment of a Partnership for Applying Measures to Improve Quality (Partnership) proposal. We recognize the thoughtful consideration of previous comments and support the NQF efforts to further elaborate on proposed member selection criteria, member responsibilities, and operating procedures. The AQA, a voluntary multi-stakeholder collaborative of physicians and other clinicians, consumers, purchasers, health plans, and others whose mission is to improve patient safety, health care quality and value in all settings, supports the direction and design of NQF's proposal as one that will optimize the success of a newly formed Partnership.

General Comments

The AQA appreciates the clarification of several areas we identified in our previous comments. We offer the following comments and identify a few areas needing additional specification. The AQA Steering Group expressed concern that more organizations did not submit comments to the Partnership proposal. Given the breadth of organizations that the National Quality Forum represents and will eventually be represented by the Partnership, we encourage NQF to consider alternative methods to ensure that perspectives from a greater number of members are reflected in the comments. A multi-pronged outreach strategy utilizing conference calls with individual organizations, webinars, letters to organization CEOs and Presidents, and more, should be considered. This approach will broaden outreach to potential Partnership organizations and promote early support that will lead to a successful effort.

Additionally, the AQA Steering Group recommends that the NQF construct the Partnership as an independent entity by establishing separate finances, budget, and staff, and dedicating resources to hold meetings and conduct independent research. This will ensure that the Partnership's processes and recommendations are unique and separate from the NQF.

Partnership Selection Criteria

The AQA Steering Group has had the opportunity to review the proposed criteria for the selection of organizations to the Partnership. The AQA agrees with the importance of and need for the following:

- *Organizations selected for the Partnership should be membership entities that represent leading stakeholder groups affected by the use of quality measures.*

- *Organizational Partnership members should have structures and processes for setting policy and communicating with their constituencies.*
- *Organizational Partnership members should contribute to a balance of stakeholder interests.*
- *Members should contribute to the diversity of the Partnership.*
- *Organizational members, as well as individual subject matter experts, should have demonstrated involvement and experience in quality measurement (e.g., development, endorsement, implementation, validation, and methodological issues), public reporting, and performance-based payment.*
- *Members should be capable of and committed to meeting Partnership member responsibilities.*

AQA shares a commitment to a membership structure that represents the full breadth of stakeholders affected by use of quality measures. We also concur with the need for a governance process that promotes input from all participants, represents a diversity of interests, and addresses needed technical expertise with performance measurement, methodological issues and reporting.

Availability of Partnership Resources
The document mentions the ability of members to volunteer time and make resources available as necessary to accomplish the work of the Partnership. We are concerned that Partnership members will be selected based on their ability to provide financial and other resources to Partnership activities. The Patient Protection and Affordable Care Act authorized and appropriated adequate financial resources for these activities; NQF should clarify that it is not seeking contribution of financial resources from the members, and that financial capacity or resources will not negatively impact selection to the Partnership.

Operating Procedures
The AQA Steering Group is concerned that voting by proxy will not be allowed by organizational members. While every effort should be made by participants to attend meetings, attendance at every meeting may not be possible. We strongly encourage NQF to establish a process by which participants may designate an alternative staff person to attend in their place and/or provide a mechanism for participants to vote on recommendations prior to meetings.

The AQA also recommends studying the roles of the chairs and vice chairs of subgroups in relation to their roles on the Coordinating Committee. This could facilitate communication of subgroup discussions and recommendations to the Partnership Coordinating Committee. We note that AQA Workgroup chairs also serve on the AQA Steering Group to represent the Workgroup's perspectives to the AQA leadership. This approach has worked well and should be considered as a successful model.

The NQF should clarify if the Coordinating Committee can change subgroup recommendations prior to submission to the Secretary. The document appears to allow for the Coordination Committee to revise subgroup recommendations without consulting with the subgroups. The AQA Steering Group recommends that the Coordinating Committee not be allowed to change subgroup recommendations without consultation with the appropriate subgroup. Having the subgroup chairs serve on the Coordination Committee will facilitate consultation between the

Coordinating Committee and subgroup if recommendations by the subgroup are not supported by the Coordinating Committee.

The AQA Steering Group appreciates the opportunity to provide these comments and looks forward to participating in future discussions that will pave the way for a successful Partnership.

Sincerely,

The AQA Steering Group

AARP
America's Health Insurance Plans
American Academy of Family Physicians
American Benefits Council
American College of Cardiology
American College of Physicians
American College of Surgeons
American Osteopathic Association
American Medical Association
American Physical Therapy Association
American Psychological Association
Consumers Union
HealthPartners
National Partnership for Women & Families
Pacific Business Group on Health
Society of Thoracic Surgeons
Wisconsin Collaborative for Health Care Quality

Federal Liaison: Agency for Healthcare Research and Quality

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August 18, 2010

Janet Corrigan, MBA, PhD
President and CEO
National Quality Forum
601 13th Street, NW
Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan,

The Association of American Medical Colleges (AAMC) is pleased to have an opportunity to comment on the revised Partnership for Applying Measures to Improve Quality (PAM) document that includes proposed member selection criteria, member responsibilities and operating procedures. We appreciate the National Quality Forum (NQF) responding to member comments and providing the additional clarification. We believe the continued clarification is essential in establishing an effective and impartial measurement entity.

First, the AAMC would like thank the NQF for responding to most of our clarifying questions posed in our previous comment letter. However, we now have additional questions and concerns with the proposed criteria and membership structure included in this letter.

We are pleased to see that representation on the PAM would consist of both individual and organizational members. It is crucial to have broad representation that includes both representatives of large stakeholder groups as well as subject matter experts in quality measurement, clinical science, and policy. However, the document fails to state the final composition of the PAM, for both the subgroups and the coordinating committee. The AAMC recommends that the composition of both the Patient Coordination Committee as well as the subgroups have balanced representation with no one group or interest having a majority of seats. The composition of the committee is extremely important as the proposed voting procedure is by simple majority. In order to maintain a fair and balanced process, no one stakeholder group should be overrepresented.

In addition, we are very concerned regarding the proposal that organizational members would not be allowed to provide a substitute for meetings. Organizations should have the opportunity to cast their vote even if the designated representative is not available. Allowing for simple majority votes without full participation will call into question the partiality of the vote. The AAMC strongly recommends NQF remove this requirement from the member responsibilities.

It appears from the proposed document that there is no overlap in representation between the subgroups and the coordinating committee. In addition, it appears that the coordinating committee would have the authority to overrule or modify the recommendations of the subgroups. In order to have a coordinated approach and to ensure clear and directed communication between the groups, we recommend that the Chair and Vice-Chair of the

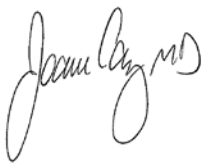
subgroups have a voting seat on the coordinating committee. The overlap between the subgroups and the coordinating committee will ensure appropriate representation of the group's perspectives and foster communication and collaboration between and among the groups on the issues PAM will be facing in the future.

Similarly, consideration should be given to allow the subgroups to coordinate their deliberations when proposed measures are beyond the scope of just one subgroup. Removing the silos and allowing for cross-subgroup communication prior to the development of any recommendations to the coordinating committee would allow for more rich conversations and greater involvement of all members of the PAM.

As we look ahead to the future implementation of the PAM, a shared goal is to ensure that the group of multi-stakeholder organizations and individuals convened by NQF is seen as an entity that operates independently and whose recommendations are a direct result of their collective engagement. NQF as the neutral convener has both a fiduciary responsibility as the contractor and as an independent arbiter of the process. With that being said, the AAMC believes that the PAM should have the maximum autonomy allowed by law to conduct the work of which they have been charged. Distinguishing the PAM as an independent effort with its own staff, and dedicated resources to conduct its meetings and research under the direction of the Chair and Vice Chair is an important infrastructure distinction that should be made between the PAM and the NQF.

Thank you again for providing further clarification and transparency on the envisioned function and direction of the PAM. This is a critical entity in the future of measure development and public reporting and we appreciate the opportunity to be involved.

Sincerely,



Joanne Conroy, M.D.
Chief Health Care Officer
Association of American Medical Colleges

Boehringer Ingelheim

Thomas Valuck, MD, JD
Senior Vice President for Strategic Partnerships
National Quality Forum
601 13th Street NW, Suite 500 North
Washington DC 20005

August 10, 2010

RE: Proposed Member Selection Criteria, Member Responsibilities, and Operating Procedures

Dear Dr. Valuck,

Hemal Shah, PharmD
Executive Director
Health Economics & Outcomes Research
Boehringer Ingelheim Pharmaceuticals, Inc.
900 Ridgebury Rd/P.O. Box 368
Ridgefield, CT 06877-0368

On behalf of Boehringer Ingelheim Pharmaceuticals, Inc., I am pleased to submit comments in response to the National Quality Forum (NQF) paper titled, "Proposed Member Selection Criteria, Member Responsibilities, and Operating Procedures" for the Partnership for Applying Measures to Improve Quality.

Boehringer Ingelheim (BI) previously submitted comments on the paper titled, "Establishment of a Partnership for Applying Measures to Improve Quality to Provide Input on Measure Selection for Public Reporting and Payment Programs." Our recommendations focused on (1) the need for additional transparency and clarity on stakeholder involvement, member selection, measure evaluation, and (2) additional specificity regarding Partnership evaluation. We commend NQF for its responsiveness to the submitted comments and for maintaining a timely, transparent process for soliciting and responding to Member and public feedback. We appreciate the opportunity to provide further comments on the Partnership member selection criteria, member responsibilities, and operating procedures. In this letter, we focus our comments specifically on the member selection criteria.

BI supports NQF's decision to ensure that the Partnership represents all stakeholder interests, both at the organization and individual levels. Including all stakeholder groups affected by quality measurement ensures balanced perspectives when considering the use of quality measures in value-based purchasing.

NQF is interested in Partnership members who have a demonstrated involvement in quality measurement, public reporting, and performance-based payment. However, we ask that NQF clarify whether individuals and organizations must have demonstrated involvement in each of these areas and, if so, to what extent. Some affected stakeholders, including consumers, suppliers, and industry, may have had limited experience in one or more of these areas due to a lack of opportunity. As such, our primary recommendation is that NQF expand upon its member selection criteria to ensure that all stakeholders affected by quality measurement have equal opportunity for appropriate representation in the Partnership.

We also continue to recommend that NQF make publicly available the expected composition of Committee representatives and member selection criteria prior to

Boehringer Ingelheim

soliciting membership nominations, and we ask that NQF provide a formal opportunity for stakeholders to submit input on the composition and criteria. BI also continues to support the opportunity to subsequently comment on the proposed Partnership roster before it is finalized. Finally, BI proposes that additional time be added to the typical NQF comment period on steering committee rosters. It is currently 14 days; we recommend that it be extended to 30 days to allow sufficient time to consider and make recommendations.

In conclusion, we look forward to working together to maximize the value of this and future initiatives for all relevant stakeholders, especially as new measures are developed.

Sincerely,

Hemal Shah, PharmD
Executive Director
Health Economics and Outcomes Research
Boehringer Ingelheim Pharmaceuticals, Inc
900 Ridgebury Road / PO Box 368
Ridgefield, CT 06877-0368

The following is a comment submitted via email on August 10, 2010:

Health Insight convenes the Nevada Partnership for Value (Charter Value Exchange), a member of the Network for Regional Healthcare Improvement. We also serve as the Medicare Quality Improvement Organization for Nevada and Utah.

We endorse the proposed criterion on page 4 requiring that organizational members of the Partnership for Applying Measures have involvement and experience in quality measurement and reporting, but we would urge that the criterion be expanded to explicitly give preference to regional multi-stakeholder collaboratives which are currently doing public reporting of quality measures (such as the organizations which are members of the Network for Regional Healthcare Improvement). We would also urge that the criteria on page 3 be expanded to require that some members of the Partnership be state and regional multi-stakeholder organizations, such as Regional Health Improvement Collaboratives, not just single-stakeholder membership groups.

Jerry Reeves MD
Vice President of Medical Affairs
Health Insight

HOSPITAL QUALITY ALLIANCE Improving Care Through Information

August 18, 2010

Janet Corrigan, MBA, PhD
President and Chief Executive Officer
National Quality Forum
601 13th Street NW, Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan,

The Hospital Quality Alliance (HQA) applauds the transparent approach NQF is taking in developing a quality measure comment process as called for in the Affordable Care Act. We appreciate NQF's responsiveness to HQA's initial comments submitted in June and would like to offer the following in response to your current request for further input:

1) Consistent with good operating principles and procedures for the Measure Partnership , HQA urges that the bodies have the maximum autonomy allowed by law to conduct the work with which they are charged, including access to dedicated staff resources, and the ability to conduct its meetings and research under the direction of the Chair and Vice Chair.

2) HQA appreciates NQF's strong commitment to balance and diversity in selection of members for the partnership. While our experience has shown that achieving balance in both expertise and stakeholder interest is not easy, we urge that the Patient Focused Coordinating Committee as well as the Subgroups have balanced representation such that all groups and interests would see themselves as fairly represented, without undue weight being given to any one group or interest.

3) HQA supports the principle that those who accept membership on one of the bodies commit to full and active participation themselves, not through surrogates or staff. HQA's experience is that utilization of proxies can work while keeping all stakeholders engaged. We believe that the norm be "principals only" where feasible, and that the Chair of the Patient Focused Coordinating Committee have the flexibility to allow exceptions to this rule.

4) The role of the Patient Focused Coordinating Committee and its relationship to the Subgroups has caused some confusion among stakeholders and HQA believes it is worthy of further deliberation. HQA encourages NQF to clearly articulate the roles and responsibilities of each group and the process that is envisioned for making final recommendations to HHS, including the appropriate times for solicitation of public comment.

Thank you for this opportunity to offer further comment and, again, please accept our appreciation for the approach NQF is taking on this critically important issue. Please do not hesitate to contact Alyssa Keefe, HQA Managing Director by phone at 202-478-9927 or by email akeefe@aamc.org if there are questions.

Sincerely,

AARP
AFL-CIO
Consumer Purchaser Disclosure Project
American Hospital Association
American Nurses Association
Association of American Medical Colleges
Federation of American Hospitals
National Association of Children's Hospitals and Related Institutions
National Association of Public Hospitals and Health Systems
The Joint Commission

Richard I. Smith
SENIOR VICE PRESIDENT
POLICY RESEARCH AND STRATEGIC PLANNING

PhRMA

August 18, 2010

Janet M. Corrigan, PhD, MBA
President and CEO
National Quality Forum
601 Thirteenth St., NW
Suite 500 North
Washington, DC 20005

Dear Dr. Corrigan:

Thank you for the opportunity to comment on the proposed member selection criteria, member responsibilities, and operating procedures of the Partnership for Applying Measures to Improve Quality (PAM).

Our comments address two points within the proposed operating procedures:

First, the "no substitutes" clause: NQF suggests that there would be two types of selected members of PAM: individuals selected because of their subject matter expertise and organizational representatives. We agree that the ideal situation would be that every member would be available for every meeting. However, situations do occur that sometimes prevent every member from participating in every meeting. We propose that a knowledgeable substitute for an organizational representative should be allowed on an infrequent basis if the organizational representative cannot participate. This substitute would be expected to be prepared for the meeting and participate in discussion. Regarding individual subject matter expert members, we agree that a "no substitutes" rule applies as that individual would be invited to participate based upon his/her expertise.

Second, the decision making provision: Currently, a simple majority of those present is required to pass a motion. We propose that this provision be modified to require a quorum of voting members of the Patient-Focused Coordinating Committee for any decisions to be made, and then a simple majority of the quorum could pass a motion. Requiring a quorum of members is standard in multi-stakeholder organizational operating procedures.

We appreciate this opportunity to submit these comments. We look forward to continuing to work with NQF to improve healthcare quality.

Sincerely,

Richard I. Smith

9687 South Run Oaks Drive ♦ Fairfax Station, VA 22039
Phone: 703-690-1987 ♦ **www.PQAalliance.org** ♦ Fax: 703-690-1756

August 16, 2010

Dr. Janet Corrigan
President and Chief Executive Officer
National Quality Forum
601 13th Street NW, Suite 500 North
Washington, D.C. 20005

Dr. Corrigan:

The Pharmacy Quality Alliance (PQA) appreciates the opportunity to comment on the NQF's proposal for the *Establishment of a Partnership for Applying Measures to Improve Quality (PAMIQ).* We support the role of the Partnership in advising the Secretary of Health & Human Services on the selection of performance measures for public reports on healthcare quality. Coordination of performance reporting systems across providers and institutions in the public sector is important. However, we strongly encourage NQF to remain flexible in the composition and number of workgroups as the types of providers affected by public reports expands beyond those currently included in HHS reports.

We agree that the steering committee should include a broad base of stakeholders, while the workgroups would contain persons with more focused expertise in specific domains. We believe that NQF will make every effort to ensure that the steering committee is truly broad in its representation. PQA is willing to work with NQF in identifying persons with appropriate expertise for the workgroups.

As NQF establishes the operating procedures for the PAMIQ, we suggest that input be obtained from the existing quality alliances. These alliances have considerable experience in building consensus across stakeholders for appropriate selection of performance measures for performance improvement and public reporting. It will also be important to establish clear guidelines for how the existing alliances, and the Quality Alliance Steering Committee, will interface with the new PAMIQ. We see the need for a continued role for the Pharmacy Quality Alliance in working with CMS, and all stakeholders in the pharmacy and drug plan sector, particularly as it relates to Medicare Part D, as well as other areas that are relevant to appropriate medication use, and medication therapy management, and we are willing to work collaboratively with the PAMIQ on matters within the scope of responsibility of PAMIQ.

We look forward to continuing our positive relationship with NQF.

Kind regards,

Laura Cranston
PQA Executive Director

cc: PQA Board of Directors