Measure Applications Partnership
Coordination Strategy for Clinician Performance Measurement
Public Comment Draft

SUMMARY

This report prepared by Measure Applications Partnership (MAP) provides a coordination strategy to the Department of Health and Human Services (HHS) and the broader field on alignment across clinician performance measurement programs. This is an important step on a path toward realizing the National Quality Strategy (NQS) priorities and goals. The report includes:

- background for the task;
- alignment considerations for measures and data sources to reduce duplication and burden;
- characteristics of an ideal measure set to promote common goals across programs and catalyze improvement;
- evaluation of the proposed Physician Value-Modifier measure set;
- data platform principles that promote standardized data sources and health information technology to ease data collection burden and leverage use of data during the course of care; and
- a pathway for improving measure applications to meet the needs of all relevant programs.

BACKGROUND

Purpose

MAP is a public-private partnership convened by the National Quality Forum (NQF) for providing input to HHS on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[1]

Through MAP activities, a wide variety of stakeholders will provide input into HHS's selection of performance measures. MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures that HHS will receive varied and thoughtful input on performance measure selection.

MAP is designed to facilitate alignment of public and private sector uses of performance measures to further the NQS's three-part aim of creating better, more affordable care and healthier people. Anticipated outcomes from MAP's work include:[2]

- a more cohesive system of care delivery;
- better and more information for consumer decision making;
- heightened accountability for clinicians and providers;
- higher value for spending by aligning payment with performance;
- reduced data collection burden through harmonizing measurement activities across public and private sectors; and
- improvement in the consistent provision of evidence-based care.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations. More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented in the Coordinating Committee and workgroups.

The NQF Board oversees MAP. The Board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness but will not review the Coordinating Committee's input to HHS. The Coordinating Committee and workgroups were selected by the Board, based on Board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups was also imperative.

MAP operates in a transparent manner. The appointment process included open nominations and a public commenting period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decision making is based on a foundation of established guiding frameworks. NQS is the primary basis for the overall MAP strategy. Additional frameworks include the High-Impact Conditions lists determined by the NQF Measure Prioritization Advisory Committee, the NQF-endorsed Patient-Focused Episodes of Care framework, the HHS Partnership for Patients safety initiative,[3] the HHS Prevention and Health Promotion Strategy,[4] the HHS Disparities Strategy,[5] and the HHS Multiple Chronic Conditions Framework.[6]

One of MAP's early activities has been the development of measure selection criteria. These criteria are intended to build on, not duplicate, the NQF endorsement criteria. The measure selection criteria characterize the fitness of a measure set for use in a specific program by, among other things, how closely it aligns with the NQS' priority areas and address the High-Impact Conditions, and by the extent to which the measure set advances the purpose of the specific program without creating undesirable consequences.

NQF has engaged two subcontractors to support MAP's work. The Stanford Clinical Excellence Research Center has provided input into developing measure selection criteria. Avalere Health has been subcontracted to prepare an analysis of quality issues, strategies for improvement, and measure gaps to support the selection of measures for hospitals, physician offices, and post-acute care/long-term care settings. In addition, Avalere will conduct a similar analysis for dual eligible beneficiaries as a distinct population that crosses all care settings.

Timeline and Deliverables

MAP's initial work includes performance measurement coordination strategies and pre-rulemaking input on the selection of measures for public reporting and payment programs (see Appendix 1 for schedule of deliverables). Each of the coordination strategies will address:

- measures and measurement issues, including measure gaps;
- data sources and health information technology (HIT) implications, including the need for a common data platform;
- alignment across settings and across public- and private-sector programs;
- special considerations for dual eligible beneficiaries; and
- the path forward for improving measure applications.

MAP began its work in the spring of 2011 (see Appendix 2 for timeline). The Coordinating Committee set charges for the workgroups in May. Four of the workgroups—Dual Eligible Beneficiaries, Clinician, Safety, and Post-Acute Care/Long-Term Care—met during June and July. The Coordinating Committee has also convened regularly to review progress and provide guidance to the workgroups. These four workgroups provided reports to the Coordinating Committee in August. The Hospital Workgroup will meet in October to consider the measure selection criteria and its approach to the pre-rulemaking task. MAP will provide pre-rulemaking input to HHS on the selection of measures for payment and public reporting programs in

February 2012, based on a list of measures under consideration that HHS will post in December. To fulfill its initial tasks, MAP will provide three reports by October 1, 2011: final reports for the clinician and safety coordination strategies, and an interim report for the dual eligible beneficiaries quality measurement strategy (with a final report due June 1, 2012).

COORDINATION STRATEGY FOR CLINICIAN PERFORMANCE MEASUREMENT

MAP has been charged with developing a coordination strategy that addresses alignment issues across federal clinician performance measurement programs. Throughout this strategy c*linician* refers to the entire team of healthcare professionals. MAP recognizes the importance of teamwork in providing care that is centered on the patient, rather than on individual clinicians. New delivery models, such as patient-centered medical homes and accountable care organizations (ACOs) are pushing toward further integration of patient-centered care. These new models call for new ways of measuring performance that promote high-performing teams and improvement in the outcomes that matter to patients.

As clinicians face increasing measure reporting requirements, stakeholders widely agree alignment is critical for reducing data collection burden, maximizing meaningfulness of the information, and accelerating improvement. To support measure alignment, MAP has identified characteristics of an ideal measure set and tested a set of measures, the proposed Physician Value-Based Payment Modifier (Value-Modifier) measure set, against those characteristics. In addition to providing an evaluation of the proposed measure set, this exercise highlighted important measure gaps and provided input into the measure selection criteria being developed by MAP to select measures for specific purposes (e.g., public reporting and performance-based payment programs). MAP also has adopted data platform principles that will further address data collection burden. Finally, MAP presents a path forward, indicating critical next steps toward achieving alignment and making available the performance measures needed to support integrated delivery.

Approach

The MAP Clinician Workgroup advised the Coordinating Committee on developing the clinician performance measurement coordination strategy. The Clinician Workgroup is a 27-member, multi-stakeholder group (see Appendix 3A for the workgroup roster). The workgroup had two, two-day in-person meetings and two web meetings to consider aspects of the coordination strategy. The agendas and materials for the Clinician Workgroup meetings can be found on the NQF website.[7]

To inform planning for the Clinician Workgroup meetings, NQF staff compiled a table of performance measures currently in use in federal programs and select private programs (see NQF website[8] for the table). Measure attributes included in the table are endorsement status, re-tooled eMeasure specification availability, description, steward, numerator, denominator, data sources, and type, as well as the corresponding settings and programs in which the measure is used. Further, each measure is mapped to targeted conditions and the NQS priorities.

The Clinician Workgroup reviewed the performance measures currently in use in federal programs—specifically, the Physician Quality Reporting System, the Medicare and Medicaid EHR Meaningful Use Incentive Program, and illustrative private-sector programs—and identified qualities that make measures suitable for broad application across performance measurement programs. The workgroup gave explicit attention to measurement challenges within the dual eligible beneficiary population, although there is a separate MAP workgroup devoted specifically to dual eligible coordination strategies. An initial attempt to define a core measure set for all clinician measurement led to a strong consensus among the group that measure sets need to be evaluated in the context of a specific purpose (e.g., public reporting vs. payment; individual vs. group accountability). Accordingly, the workgroup defined characteristics of ideal measure sets that are applicable to multiple purposes. The group examined how a measure set proposed for a specific program, the physician Value-Modifier, aligns with the ideal characteristics, using draft measure selection criteria as an evaluation tool (see Appendix 4A for the evolution of the measure selection criteria).

Considering data collection and reporting challenges across federal programs led to developing data platform principles. Discussing other ongoing efforts, specifically the work of the National Partnership (NPP) to define goals and measures for the NQS priorities and efforts to develop measures for ACOs, raised additional alignment imperatives.

Alignment

Multiple federal programs involve clinician performance measurement (see Appendix 5 for an overview of federal programs). The differing goals and structures of these programs create issues that can cause undue burden for clinicians and groups participating in multiple programs and confusion for those who use performance improvement information for decision making. The federal programs for clinician performance measurement are briefly described below:

- *The Physician Quality Reporting System* (PQRS) provides incentive payments to eligible professionals who satisfactorily report data on quality measures (selected from among 240 measures) for covered services furnished to Medicare beneficiaries.[9]
- *The Medicare and Medicaid EHR Meaningful Use Incentive Program* (EHR-MU) provides incentive payments to eligible professionals (as well as eligible hospitals) for the

"meaningful use" of certified electronic health record (EHR) technology to enhance quality, safety, and effectiveness of care.[10]

- *The E-Prescribing Incentive Program* (ERx) provides incentive payments to eligible professionals who are successful electronic prescribers.[11]
- *The Physician Resource Use Measurement and Reporting (RUR) Program,* which will be incorporated into the *Physician Feedback/Physician Value-Based Payment Modifier Program* (Value-Modifier), currently provides confidential feedback reports to physicians and other medical professionals. These reports gauge the resource use and quality of care provided to patients in comparison to the peer groups practicing in the same specialty.[12]
- *The Physician Compare website* currently serves as a healthcare professional directory but will be enhanced to provide performance information.

Clinicians who participate in the PQRS, EHR-MU, and ERx incentive programs face measure and data alignment issues that make participation burdensome and confusing. The misalignment of programs induces duplication of efforts, which increasingly taxes clinicians' limited resources and time available for quality improvement. For example, a recent Government Accountability Office report on electronic prescribing notes that the misalignment of technology certification requirements between ERx and EHR-MU programs creates the possibility clinicians will invest in technology that may not be suitable for both programs.[13] With the ERx program scheduled to introduce penalties in 2012 when the EHR-MU program will be providing incentives, clinicians could invest in technology to avoid a penalty from the ERx program that may not be suitable to receive incentives from the EHR-MU program.[14] Additionally, a clinician currently participating in both programs must report the same electronic prescribing information to each program separately due to the varying reporting requirements.[15] The Centers for Medicare & Medicaid Services (CMS) has since indicated their intent to better align these two programs, the details of which are captured in the 2012 Medicare Physician Fee Schedule proposed rule.[16]

The importance of alignment is only growing, as Physician Compare and Value-Modifier programs will depend on data generated from clinician participation in the PQRS and EHR-MU programs. Issues include different data sources (e.g., claims, EHRs) and reporting periods for the same measure resulting in different specifications across programs; separate reporting mechanisms for the same measure (e.g., submission of data for PQRS and submission of rates for EHR-MU); and inconsistency in allowing group reporting. Given these differences, a measure concept that overlaps programs may have up to seven different reporting options that vary by data sources, specifications, and reporting periods. Measure results generated from these seven different reporting options may not be comparable and may cause confusion in interpreting performance results.

There is broad recognition that the need to align clinician performance measurement programs extends beyond federal programs to private-sector initiatives. Addressing federal program alignment issues creates opportunities to align broadly with private-sector initiatives. For example, PQRS now gives credit for Medical Specialty Board Maintenance of Certification (MOC), and several certification boards have incorporated a PQRS reporting option into their MOC programs. Each well-intentioned public and private performance measurement initiative imposes data collection requirements on clinicians that could potentially conflict with the requirements for other programs. Medical home initiatives typically include health IT structural and process requirements (e.g., EHRs, e-prescribing); CMS has proposed 65 process and outcome measures across 5 domains for ACOs;[17] and many health plans have created clinician performance measurement programs (e.g., BCBS-MA Alternative Quality Contract, [18] IHA Pay for Performance[19]). Clinicians may become linked to several of these programs that occur at multiple levels of the system (e.g., clinician, group, health plan, or system).

Measurement approaches targeted to one program or setting create duplicity of measurement and further perpetuate "silos" in the healthcare system. Ideally, an aligned measurement approach would use "cascading measures," harmonized measures applied at each level of the system, to provide a comprehensive picture of quality and identify targeted interventions at each level of the system. Using standardized data elements to calculate measures across levels of analysis would further reduce data collection burden. The NQS priorities and goals serve as a guide for aligning public and private efforts. NPP has identified measures for tracking progress on the national priorities and goals of NQS, while MAP identifies specific measures that can help to move the needle at the provider and clinician levels.

Characteristics of an Ideal Measure Set

MAP has identified seven characteristics of an ideal measure set to encourage alignment across federal programs and between public- and private-sector programs. The ideal measure set represents measurement areas that should be incorporated into any measurement program. The ideal set bridges federal programs and the private sector's quality initiatives by denoting measure characteristics that are comprehensive, yet flexible enough to address multiple applications.

Measure sets should promote shared accountability and "systemness."

Patients should receive care in a seamless delivery system in which there is communication and coordination across the healthcare providers and settings that are jointly held accountable for the patient's care. The healthcare team or an individual clinician should be able to influence the

result of the measure (i.e., actionable), and the measure should target an improvement gap (i.e., not "topped-out"). To promote system coordination and improvement, measures should assess care across settings and time (i.e., longitudinal).

Measure sets should address multiple levels of analysis, using "cascading" measures for harmonization across levels.

Clinician performance measurement programs may permit different levels of data reporting (i.e., individual vs. group) to serve different purposes. Group-, team-, or system-level analysis promotes shared accountability, while individual-level analysis promotes action for specific individuals. Using cascading measures that are harmonized across multiple levels of the system would align interventions. For example, while the percentage of smokers/tobacco users referred to community-based smoking cessation resources can be assessed at the individual level, smoker/tobacco user population rates also can be evaluated at the group, team, or system level.

Measure sets should be useful to the intended audiences, including consumers, clinicians, payers, and policymakers.

Recognizing that measures are used by current and future Medicare programs, they should not only serve Medicare's purposes, but also their results must be understandable and meaningful to patients and clinicians. The information garnered from the measure set should inform patients' healthcare decisions and provide feedback to providers on how to improve care. In addition, payers and policymakers should be able to use this information to evaluate and improve programs.

Measure sets should include appropriate representation among types of measures: outcome, process, structure, experience, and cost measures.

Each type of measure plays an important role in improving quality and promoting accountability. While outcome measures are needed to assess the impact of a given intervention, including process measures is vital to documenting and adopting best practices. Structural measures may be important where access to healthcare services is a particular concern (e.g., the dual eligible beneficiary population). Additionally, evaluating patient experience is a first step toward patient-centeredness and consideration of the patient's goals and preferences. Incorporating cost measures is imperative to addressing the affordability of healthcare.

Measure sets should balance comprehensiveness with parsimony, recognizing that few measures will address all of the measure selection principles.

Efforts devoted to data collection steal resources from efforts devoted to quality improvement. To achieve the goal of being as efficient as possible to reduce undue data collection burden and duplicative measurement efforts, measure sets should use the best measures to address the

purpose of the program adequately. This can be accomplished by including measures that not only gauge quality and performance, but also lead to the most effective interventions.

Consideration should be given to the potential for undesirable consequences from measurement.

Depending on the type of measure selected, risk adjustment or stratification may be needed to recognize the complexity of certain subpopulations and the need to avoid incentives for "cherry picking," while not adjusting away disparities that need to be addressed. Measurement approaches that can mitigate undesirable consequences include giving credit for improvement (i.e., delta measures) and incorporating programmatic features to monitor the potential for undesirable consequences.

Measure sets should include considerations for healthcare disparities.

Incorporating considerations for healthcare disparities in a measure set will assist in understanding and addressing the unique needs of vulnerable populations, including the Medicare-Medicaid dual eligible population. Healthcare disparities can be addressed by including direct measures (e.g., availability of translation services) or by stratifying measures on factors such as race, ethnicity, gender, rural location, or socioeconomic status to elicit potential opportunities to improve healthcare disparities.

Measure Selection Criteria

MAP is developing measure selection criteria as a tool to evaluate and recommend measure sets for specific public reporting and performance-based payment programs. Using measure selection criteria helps determine if a set of measures demonstrates the characteristics of an ideal measure set, as described by MAP's measure selection principles. More information on the development of the measure selection criteria can be found in Appendix 4.

MAP "Working" Measure Selection Criteria

1. ***Measures within the set meet NQF endorsement criteria***
   Measures within the set meet NQF endorsement criteria: important to measure and report, scientifically acceptable measure properties, usable, and feasible. (Measures within the set that are not NQF endorsed but meet requirements for submission, including measures in widespread use and/or tested, may be submitted for expedited consideration).
   Response option:

Yes/No: Measures within the measure set are NQF endorsed or meet requirements for NQF submission (including measures in widespread use and/or tested)[1]

2. ***Measure set adequately addresses each of the National Quality Strategy (NQS) priorities***

Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities (Appendix 4F: Table 1):

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

Response option for each subcriterion:

Yes/No: NQS priority is adequately addressed in the measure set

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

Demonstrated by the measure set addressing Medicare high-impact conditions; child health conditions and risks; or conditions of high prevalence, high disease burden, and high cost relevant to the program's intended population(s). (Appendix 4F: Table 2 for Medicare High-Impact Conditions and Child Health Conditions determined by NQF's Measure Prioritization Advisory Committee.)

Response option:

Yes/No: Measure set adequately addresses high-impact conditions relevant to the program's intended population(s)

4. ***Measure set promotes alignment with specific program attributes***

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

Response option:

Subcriterion 4.1	Yes/No: Measure set is applicable to the program's intended provider(s)
Subcriterion 4.2	Yes/No: Measure set is applicable to the program's intended care setting(s)
Subcriterion 4.3	Yes/No: Measure set is applicable to the program's intended level(s) of analysis
Subcriterion 4.4	Yes/No: Measure set is applicable to the program's population(s)

5. ***Measure set includes an appropriate mix of measure types***

[1] Individual endorsed measures may require additional discussion and may not be included in the set if there is evidence that implementing the measure results in undesirable unintended consequences.

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

Response option:

Subcriterion 5.1	Yes/No: Outcome measures are adequately represented in the set
Subcriterion 5.2	Yes/No: Process measures with a strong link to outcomes are adequately represented in the set
Subcriterion 5.3	Yes/No: Experience of care measures are adequately represented in the set (e.g. patient, family, caregiver)
Subcriterion 5.4	Yes/No: Cost/resource use/appropriateness measures are adequately represented in the set
Subcriterion 5.5	Yes/No: Structural measures and measures of access are represented in the set when appropriate

6. ***Measure set enables measurement across the patient-focused episode of care***[20]

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

Response option:

Subcriterion 6.1	Yes/No: Measures within the set are applicable across relevant providers
Subcriterion 6.2	Yes/No: Measures within the set are applicable across relevant settings
Subcriterion 6.3	Yes/No: Measure set adequately measures patient care across time

7. ***Measure set includes considerations for healthcare disparities***[21]

Demonstrated by a measure set that promotes equitable access and treatment by addressing race, ethnicity, socioeconomic status, language, gender, or age disparities. Measure set also can address populations at risk for healthcare disparities (e.g., patients with behavioral/mental illness).

Response option:

Subcriterion 7.1	Yes/No: Measure set includes measures that directly address healthcare disparities (e.g., interpreter services)
Subcriterion 7.2	Yes/No: Measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack)

8. Measure set promotes parsimony

Demonstrated by a measure set that supports efficient (i.e., minimum number of measures and the least burdensome) use of resources for data collection and reporting and supports multiple programs and measurement applications.

Response option:

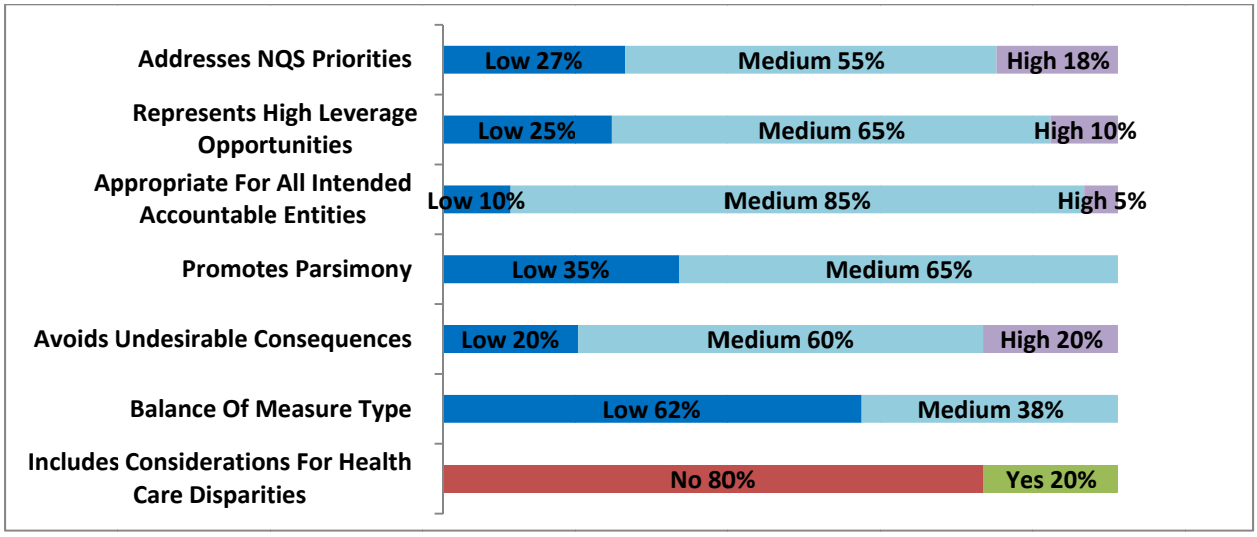
Subcriterion 8.1	Yes/No: Measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome)

Subcriterion 8.2 Yes/No: Measure set can be used across multiple programs or applications (e.g., Meaningful Use, Physician Quality Reporting System [PQRS])

Evaluating the CMS Value-Based Payment Modifier Proposed Quality Measure Set

The Clinician Workgroup evaluated the Physician Value-Based Payment Modifier[22] (Value-Modifier) quality measure set that was published in the 2012 Medicare Physician Fee Schedule proposed rule, using a version of the MAP measure selection criteria (see Appendix 4B for the draft criteria). The MAP Hospital and Post-Acute Care/Long-Term Care workgroups will be engaging in a similar exercise of applying measure selection criteria to relevant measure sets. The Value-Modifier quality measure set was selected for review because it applies to both individual and group or team levels of analysis and because of its significance as the initial set of measures for the Value-Modifier program, which will be the first performance-based payment program to be applied to all clinicians participating in Medicare. With implementation of the Value-Modifier program set for 2015, CMS is required to establish an initial core set of quality measures by January 1, 2012. The core set will be augmented by incorporating additional quality and cost measures over time. The initial Value-Modifier proposed set includes measures from the PQRS and EHR-MU programs for 2012. A list of the proposed quality measures for the Value-Modifier can be found in Appendix 6.

The graph below reflects the extent to which the Clinician Workgroup found the proposed Value-Modifier measure set met each criterion in the draft measure selection criteria:



The workgroup members provided the following rationale in support of their responses:

Addresses NQS priorities

The Value-Modifier proposed measure set addresses most NQS priorities but does not necessarily cover the true intent of the priority. Whereas treatment and secondary prevention (i.e., clinical effectiveness) measures dominate the set, measures representing patient-centeredness are notably absent. Other NQS priorities—healthy living, care coordination, affordability, and safety—also are inadequately represented in the measure set.

Represents high-leverage opportunities

The measure set heavily addresses conditions that have been a focus for years, such as cardiovascular conditions and diabetes. Less consideration is given to other high-leverage opportunities for improvement, such as care coordination measures that cut across conditions and measures of patient experience.

Appropriate for all intended accountable entities

The measure set is appropriate for individual clinicians and groups or teams of clinicians, though focused on primary care. Team-based care, pediatrics (by design for this Medicare program), and most specialties are not addressed. The lack of measures related to specialties and team-based care may hinder shared accountability and understanding the performance of the entire system. Moreover, some measures may not have sufficient sample size to calculate rates for individual clinicians.

Promotes parsimony

The lack of measures that cross conditions and specialties works against parsimony for the set. Focus on systems of care beyond specific conditions would help achieve parsimony. The alignment with EHR-MU measures should be stronger to reduce duplication and data collection burden. Removing duplicative hypertension and lipid control measures from the set would further reduce burden.

Avoids undesirable consequences and healthcare disparities

Attention to downstream consequences is important, as all measures have the potential for undesirable consequences (e.g., adverse selection). However, the group found it difficult to assess the measure set for potential undesirable consequences and disparities, given the information in the proposed rule. Program implementation could include processes to monitor and detect undesirable consequences and disparities.

Balance of measure types

The measure set is dominated by process measures. Outcomes, experience, and cost have minimal or no representation. While not yet fully specified, cost information ultimately will be a part of the Value-Modifier. The addition of clinician-group CAHPS, which assesses patient experience, would greatly enhance the measure set.

Gaps in the Value-Modifier measure set

MAP identified gaps in the measure set in the areas of patient preferences, patient experience, functional status, quality of life, care coordination, mental and behavioral health, cost, overuse, and appropriateness.

Data Platform Principles

Promoting standardized electronic data sources and health IT adoption has the potential to reduce data collection burden so clinicians can eventually collect data once and use it for multiple quality measurement purposes and programs. The following data platform principles recommend processes that will reduce quality measurement burden and facilitate health IT adoption. These principles are in concert with current efforts to define standardized data elements and distributed data models (e.g., NQF developed Quality Data Model,[23] PCAST Report,[24] ONC HITPC,[25] QASC[26]).

Principle #1: A standardized measurement data collection and transmission process should be implemented across all federal programs, and ultimately all payers.

A unified process across all public and private payers would significantly reduce provider burden. Current technology uses multiple data formats that primarily enable point-to-point exchange of administrative information and limited clinical data.[27] Current performance measurement suffers from these disjointed data formats, which create an incomprehensive view of quality and duplicity of measurement activities. Health information exchanges are an example of a mechanism that promotes standardization.

Principle #2: A library of all data elements needed for all measures (i.e., an inventory of all standardized data elements) should be defined and maintained. The data element library should be broad and deep enough to allow for innovation and flexibility in measurement.

Data elements should include all information needed to calculate measures, including data elements that could support risk adjustment and stratification. As no individual source of data is sufficient for quality measurement, the data elements may be generated from multiple sources of data including, but not limited to, claims, pharmacy data, lab or other clinical results, registries, or EHRs. Cost elements should be included in the library to better collect data on affordability of care. Ideally, EHR certification requirements would include capturing all of the data elements to calculate the measures in core sets.

Principle #3: The data platform should support patient-centered measurement by enabling the collection of patient-reported data (both quantitative and qualitative) and the tracking of care across settings and over time.

Availability of patient-level data facilitates care coordination when every specialist or setting has access to accurate and up-to-date information.[28] Additionally, use of patient identifiers, along with mechanisms to ensure patient confidentiality, would enable patient-centered measurement across providers, payers, and time.

Principle #4: Data collection should occur at the individual clinician level when analysis is appropriate at that level; data also should enable group/team-level analysis.

Patient-level data can be used for analysis at any level (e.g., individual, group or team, system). Individual level analysis can help consumers and clinicians make decisions in selecting clinicians, while group- or team-level analysis promotes team accountability.

Principle #5: Data collection should occur during the course of care, when possible.

Data collection burden should be minimized by capturing data as a part of workflow, including clinical interactions that are outside of typical in-person clinical encounters (e.g., clinician phone conversations with patients). Data should be available for use in clinical decision making.

Principle #6: Processes such as clinician review of data and feedback loops should be implemented.

Clinician review and feedback can help ensure data integrity, inform continuous improvement of data validity and measure specifications, and enhance clinician engagement and support for performance measurement efforts.

Principle #7: Timely feedback of measurement results is imperative to support improvement of care by clinicians and more informed decisions by consumers.

Timeliness standards that minimize the lag time from data collection to analysis, and then to reporting, should be adopted. Ideally, feedback would be at the point of care to provide clinical decision support and enable real-time quality improvement.

In operationalizing these principles, multiple considerations will need to be taken into account. Clinicians are at various stages of readiness. Data collection will need to happen through existing and new sources while the infrastructure is developing. Difficult issues related to privacy, confidentiality, ownership, and access to data will need to be resolved, as will distribution of implementation costs.

Pathway for Improving Measure Applications

Core Sets

Currently, public and private programs may have similar aims (e.g., public reporting, encouraging health IT adoption, performance-based payment) yet use varying measure sets, introducing unnecessary burden, complexity, and costs for clinicians and others who are using performance information for various purposes. In addition to using cascading measures across multiple levels of analysis, identification of core sets or subsets for specific purposes is needed to enhance alignment across public and private sector programs. Core sets also can support community-based efforts to implement performance measurement programs by providing vetted measures as a starting point and creating opportunities to benchmark outside of their communities.

Priority Measure Gaps

Considering the ideal measure set highlights gaps in the currently available quality measures. One priority gap area is measures that capture the patient's perspective by incorporating patient-reported data. Patient-reported measures include measures of experience, shared decision making about care goals, functional status and quality of life, and assessment of health risk. A second priority gap area is appropriateness of care measures, as misuse and overuse of interventions can significantly increase harm to patients and unnecessary cost. Appropriateness measures also can help to understand defensive medicine.

A third priority gap area is measures that are most relevant to vulnerable populations, such as Medicare-Medicaid dual eligible beneficiaries. These measures include the assessment of multiple comorbidities; physical and mental disabilities; and cultural competency, language, and health literacy. A fourth priority gap area is care coordination measures, specifically the coordination of care across multiple settings and providers and the adequacy of community supports. A fifth priority gap area is measures recognizing the team-based nature of quality care. Indices of high-performing teams include leadership, training, information sharing, and culture.

Coordinated Strategy for Gap Filling

It is imperative to address the measure gaps through federal and private support for developing, testing, and endorsing measures. While the NQS should guide gap-filling priorities, a coordinated strategy is needed to ensure the most efficient path for addressing gaps. In the absence of a coordinated strategy, resources will be wasted and there will continue to be a proliferation of program-specific measures. Various federal and private sector entities have begun to coordinate measure development. For example, the Children's Health Insurance Program Reauthorization Act (CHIPRA) established the Pediatric Quality Measurement

Program[29] to enhance and improve initial core measure sets through coordinated measure development conducted by grantees and contractors. Both de novo measure development and harvesting of innovative quality measures already tested and used within that private sector, but not yet NQF endorsed, should be pursued. The strategy for gap filling also must consider the funding needed to develop, test, endorse, and maintain measures. In recognition of the need to fund the quality measurement infrastructure, section 3013 of the Affordable Care Act authorized $75 million per year for measure development; however, no funding has been appropriated.

The steps below capture the critical pathway for improving measure applications:

Innovative approaches to care should be identified for possible broader application. For example, findings from the Patient-Centered Outcomes Research Institute (PCORI[30]) should be readily incorporated into measures. Additionally, the impact of measure application should be evaluated for continuous improvement.

Recognizing that individual clinicians and groups of clinicians are at various stages of infrastructure development, interim "ramping up" solutions are needed for public- and private-sector performance measurement programs. A practical approach would be to include measures that can be collected and reported with current data infrastructure capabilities now, while encouraging and supporting a progression toward collecting and reporting advanced measures. Measures that are easily calculable with administrative data or by survey data can be used now;

measures that require clinical data and data from EHRs are becoming feasible; and measures of longitudinal, patient-centered care are on the horizon.

NOTES

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Appendix 1

Measure Applications Partnership - Schedule of Deliverables

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

Appendix 2

HHS Task 15 - Timeline by Group -- REVISED August 11

Group	2011									2012					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
MAP Coordinating Committee Sets charges for all workgroups and centralizes input; provides pre-rulemaking input to CMS (15.1)	**April 8 10a-12p** - 2 hr web meeting	**May 3 -4** - 2 day in-person meeting: big picture planning, charge for workgroups, framework **May 13 2-4p** - 2 hr ALL MAP optional attendance at group web meeting	**June 21-22** - 2 day in-person meeting, clinician coordination strategy, safety input, duals input, framework	**Aug 5 11a-1p** - 2 hr web meeting	**Aug 17-18** - 2 day in-person meeting, HACs and readmissions, finalize WG input for September reports, begin work on quality issues in 11 settings		**Oct 19 2-4p** - 2hr web mtg	**Nov 1-2** - 2 day in-person meeting, finalize PAC report, finalize quality issues in 11 settings	**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework	**Jan 5-6** - 2-day in-person meeting to finalize pre-rulemaking input 1-2 week public comment period	**REPORT Feb 1st 15.1** Early Feb - informational public webinar Late Feb - 2 hr web meeting	Mid March - 2 day in-person meeting, finalize input on June reports			
Clinician Workgroup Coordination of measures for physician performance improvement (15.2a), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 7-8** - 2 day in-person meeting, framework, strategy for coordination of physician measurement, HACs & readmissions **June 30 1-3p** - 2 hr web meeting	**July 13-14** - 2 day in-person meeting to finalize strategy and themes for report on physician performance measurement	**Aug 1 10-11a** - 1 hr web meeting late Aug - 2 week public comment period for physician strategy and HACs/readmissions	**REPORT Sept 30th 15.2a**			**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework **Dec 12** - 1 day in-person meeting to react to proposed measures						
Hospital Workgroup Measures for PPS-exempt cancer hospitals (15.2c), major input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework						**Oct 12-13** - 2 day in-person meeting to discuss hospital coordination framework and finalize measures for cancer hospitals	**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework **Dec 15** - 1 day in-person meeting to react to proposed measures			Early April - public webinar and 30 day comment period on draft report	**REPORT June 1st 15.2c**		
Ad Hoc Safety Workgroup HACs & readmissions (15.4)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 9-10** - 2 day in-person meeting with additional panelists, consider HACs & readmissions, framework	**July 11-12** - 2 day in-person meeting, review other groups' work on HACs and readmissions to finalize report on HACs & readmissions	late Aug - 2 week public comment period for physician strategy and HACs/readmissions	**REPORT Sept 30th 15.4**									

Measures published **by CMS on December 1**

* All dates are tentative and highly subject to change. Bolded dates confirmed final.

HHS Task 15 - Timeline by Group -- REVISED August 11

Group	2011									2012					
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Measures published **by CMS on December 1**	Dec	Jan	Feb	Mar	Apr	May	Jun
Dual Eligible Beneficiaries Workgroup Identify quality issues specific to duals and appropriate measures and measure concepts (15.3); some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 2-3** - 1.5 day in-person meeting to discuss duals' quality issues, HACs & readmissions, framework	**July 6 11a-1p** - 2 hr web meeting **July 25-26** - 2 day in-person meeting to continue discussion of quality issues, finalize preliminary themes for report		**Interim REPORT Sept 30th 15.3**	**Oct 19 -** 30 day public comment period	**Nov 15** - 1 day in-person meeting, present public and HHS feedback, begin next phase		**Dec 8 1-3p** - ALL groups on 2 hr web meeting to distribute measures with homework **Dec 16** - 2 hr web meeting to react to proposed measures	Late Jan - 2 hr web meeting	Mid Feb - 2 day in-person meeting to finalize measure concepts and themes for report		Early April - public webinar and 30 day comment period on draft duals report		**REPORT June 1st 15.3**
PAC/LTC Workgroup Measures and coordination for Medicare PAC programs (15.2b), measures for hospice care (15.2d), some input on HACs & readmissions (15.4), pre-rulemaking (15.1)		**May 13 2-4p** - 2 hr ALL MAP group web meeting to explain overall project and processes, build understanding of charge and framework	**June 28** - 1 day in-person meeting, consider HACs & readmissions, framework			**Sep 8-9** - 2 day in-person meeting to discuss measures for PAC and coordination strategy		Nov 21 (11a-1p), Nov 29 (1a- 3p), or Dec 2 (10a-12p)- 30 day public comment period on PAC report and public webinar to introduce public comment on PAC report		**Dec 8 1-3p** - ALL MAP groups on 2 hr web meeting to distribute measures with homework Dec 14 - 1 day in-person meeting to react to proposed measures		**REPORT Feb 1st 15.2b** Mid Feb - 2 hr web meeting Late Feb - 2 day in-person meeting to finalize measures for hospice		Early April - public webinar and 30 day comment period on draft hospice report		**REPORT June 1st 15.2d**

* All dates are tentative and highly subject to change. Bolded dates confirmed final.

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)
Roster for the MAP Clinician Workgroup

Chair (voting)
Mark McClellan, MD, PhD

Organizational Members (voting)	Representatives
American Academy of Family Physicians	Bruce Bagley, MD
American Academy of Nurse Practitioners	Mary Jo Goolsby, EdD, MSN, NP-C, CAE, FAANP
American Academy of Orthopaedic Surgeons	Douglas Burton, MD
American College of Cardiology	Paul Casale, MD, FACC
American College of Radiology	David Seidenwurm, MD
American Speech-Language-Hearing Association	Janet Brown, MA, CCC-SLP
Association of American Medical Colleges	Joanne Conroy, MD
Center for Patient Partnerships	Rachel Grob, PhD
CIGNA	Richard Salmon MD, PhD
Consumers' CHECKBOOK	Robert Krughoff, JD
Kaiser Permanente	Amy Compton-Phillips, MD
Minnesota Community Measurement	Beth Averbeck, MD
Physician Consortium for Performance Improvement	Mark Metersky, MD
The Alliance	Cheryl DeMars
Unite Here Health	Elizabeth Gilbertson, MS

Expertise	Individual Subject Matter Expert Members (voting)
Disparities	Marshall Chin, MD, MPH, FACP
Population Health	Eugene Nelson, MPH, DSc
Shared Decision Making	Karen Sepucha, PhD
Team-Based Care	Ronald Stock, MD, MA
Health IT/ Patient Reported Outcome Measures	James Walker, MD, FACP
Measure Methodologist	Dolores Yanagihara, MPH

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Darryl Gray, MD, ScD
Centers for Disease Control and Prevention (CDC)	Peter Briss, MD, MPH

Centers for Medicare & Medicaid Services (CMS)	Michael Rapp, MD, JD, FACEP
Health Resources and Services Administration (HRSA)	Ian Corbridge, MPH, RN
Office of the National Coordinator for HIT (ONC)	Thomas Tsang, MD, MPH
Veterans Health Administration (VHA)	Joseph Francis, MD, MPH

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

NATIONAL QUALITY FORUM

Measure Applications Partnership (MAP)

Roster for the MAP Coordinating Committee

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

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

NATIONAL QUALITY FORUM

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

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

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

Appendix 4A

MAP Measure Selection Criteria
Developmental Timeline

Purpose: To develop measure selection criteria for public reporting; payment programs; and program monitoring and evaluation

May 2011 | June 2011 | July 2011 | August 2011

May 3-4 Coordinating Committee In-person Meeting

Inputs include:
- Stanford work
- NQF endorsement process – should not duplicate but build on endorsement process

Output- Measure Selection Principles:
- Promoting "systemness"(e.g., joint accountability, care coordination)
- Addresses the patient perspective
- Actionable by providers
- Enables longitudinal measurement across settings and time
- Contributes to improved outcomes
- Incorporates cost
- Promotes adoption of health IT
- Promotes parsimony

June 7-8 Clinician In-person Meeting

Inputs include:
- Stanford work
- Coordinating Committee Input

Output- Measure Selection Principles:
- Promoting "systemness"(e.g., joint accountability, care coordination)
- Addresses the patient perspective
- Actionable by providers
- Enables longitudinal measurement across settings and time
- Contributes to improved outcomes
- Incorporates cost
- Promotes adoption of health IT
- Promotes parsimony
- **Addressing various levels of analysis**
- **Useful to intended audiences, including consumers, clinicians, payers and policymakers**
- **Consideration given to unintended consequences**
- **Balancing comprehensiveness with parsimony**

Bold Above – New items

June 21-22 Coordinating Committee In-person Meeting

Inputs include:
- Stanford work
- Clinician Workgroup priority principles
- NQF Staff synthesis

Output –"Strawperson" Version 2

Suggested Measure Set Level Criteria:
- Align with priorities in the National Quality Strategy
- Address Health and health care costs across the lifespan
- Include measures of total cost of care, efficiency, and appropriateness
- Be understandable, meaningful, and useful to the intended audiences
- Core and advanced measure sets should be parsimonious and foster alignment between public and private payers to achieve a multi-dimensional view of quality
- Have safeguards in place to detect or mitigate unintended consequences
- Address specific program features

Suggested Individual Measure Criteria:
- NQF endorsed
- Build on measure endorsement thresholds
- Measures tested for the setting and level of analysis in which it will be implemented
- Ensures measures have broad applicability across populations and settings
- Ensure adequate sample size

July "Working" Measure Selection Criteria

Individual Measure Criteria:
- Measure addresses National Quality Strategy priorities and high-leverage measurement areas
- Measure meets NQF endorsement criteria
- Measure promotes parsimony through applicability to multiple populations and providers
- Measures enables longitudinal assessment of patient-focused episode of care
- Measure is ready for implementation in the context of a specific program
- Measure is proximal to outcomes

Measure Set Criteria:
- Measure set provides a comprehensive view of quality – NQS
- Measure set provides a comprehensive view of quality – high leverage opportunities
- Measure set is appropriate for all intended accountable entities
- Measure set promotes parsimony
- Measure set avoids undesirable consequences
- Measure set has a balance of measure types
- Measure set includes considerations for health care disparities

August "Working" Measure Selection Criteria

Criteria:
- Measures within the set meet NQF endorsement criteria
- Measure set adequately addresses each of the National Quality Strategy Priorities
- Measure set adequately addresses high impact conditions relevant to the programs intended population(s) (e.g., children, adult non-Medicare, older adults, dual eligible beneficiaries)
- Measure set promotes alignment with specific program attributes
- Measure set includes an appropriate mix of measure types
- Measure set enables measurement across the patient-focused episode of care
- Measure set includes considerations for health care disparities
- Measure set promotes

Next Steps

- Public Comment
- MAP Hospital Workgroup Input
- MAP Post-Acute/Long-term Care Workgroup Input

MAP "Working" Measure Selection Criteria

Rating Scale for Individual Measure Review – contribution to a comprehensive measure set for accountability

1. **Measures contribute to a multidimensional view of quality focused on the greatest burden**
   Demonstrated by addressing the priorities in National Quality Strategy (Table 1) or addressing conditions of the greatest burden and potential gain to patients and the population (Table 2)
   Rating:
   - Low: measure does not address any of the priorities in the NQS nor represent a measure of a high impact condition
   - Medium: measure represents one of the priorities of the NQS or a single high impact condition
   - High: measure represents multiple (more than one) priorities of the NQS and a high impact condition

2. **Measures are Important to measure and report, have Scientifically Acceptable measure properties, Usable, and Feasible (i.e., address a performance gap, evidence-based, reliable, allow valid conclusions about quality, useful for accountability and improvement, and feasible to implement)**
   Demonstrated by undergoing and receiving NQF endorsement
   Rating:
   - Low: measure development required or measure under development
   - Medium: measure development completed, but not submitted to NQF
   - High: measure in pipeline for endorsement or endorsed by NQF

3. **Measures have broad applicability to promote parsimony and inclusiveness of intended accountable entities**
   Demonstrated by applicability across multiple types of providers, levels of analysis, care settings, and conditions
   Rating:
   - Low: measure is limited to a narrow subset of providers, levels of analysis, care settings, or conditions
   - Medium: measure is applicable to primary (general) care and specialty providers (services) in a limited set of care settings or conditions
   - High: measure is applicable across multiple types of providers, levels of analysis, care settings, and conditions

4. **Measures enable longitudinal assessment of patient-focused episode of care**
   Demonstrated by assessing care across time or with the patient as the unit of analysis
   Rating:
   - Low: measure is focused on a narrow phase of an entire episode of care (e.g., point in time, single encounter, acute care stay)
   - Medium: measure provides an assessment of care across some settings of care or time
   - High: measure provides an assessment of care across a broad range of settings of care and time

5. **Measures are ready for implementation in the context of a specific program**
   Demonstrated by prior operational use in the specific context or specified and tested for the setting and level of analysis needed for the specific program
   Rating:
   - Low: measure has not been in use, nor is it specified and tested for the setting and level of analysis needed for the program
   - Medium: measure is specified and tested for the setting and level of analysis needed for the program
   - High: measure has been tested and is in operational use in the specific context or specified for the setting and level of analysis needed for the specific program

6. **Measures promote a highly reliable system of care (i.e., delivery of the right care every time)**
   Demonstrated by focusing on outcomes, composites of all necessary interventions, and processes most proximal to desired outcomes, or with strong evidence chain from distal processes to desired outcomes
   Rating:
   Low: Measures a distal structure or process that requires additional steps to influence desired outcomes (e.g., the frequency of assessing a lab value)
   Medium: Process proximal to desired outcome (e.g., administering flu vaccine); or strong evidence chain for links to desired outcome (e.g., mammography screening)
   High: Outcome or composite of all required interventions

Rating Scale for Measure Set Review – final check review of the entire set as a whole

1. **Measure set provides a comprehensive view of quality - NQS**
   Demonstrated by measures within the set addressing all of the NQS priorities
   Rating:
   Low: measure set addresses less than 1-2 of the NQS priorities
   Medium: measure set addresses at least 3-4 of the NQF priorities
   High: measure set addresses 5-6 of the NQS priorities

2. **Measure set provides a comprehensive view of quality – high impact conditions**
   Demonstrated by measures within the set addressing high impact conditions identified for the intended accountable entities
   Rating:
   Low: measure set addresses a few (or <25%) of the identified high impact conditions
   Medium: measure set addresses some (25-50%) of the identified high impact conditions
   High: measure set addresses most (over half) of the identified high impact conditions

3. **Measure set includes measurement of all intended accountable entities and promotes parsimony to support efficient use of resources for data collection, measurement, and reporting through the smallest number of measures needed to address the National Quality Strategy and high impact conditions**
   Demonstrated by a measure set which is applicable across multiple types of providers, care settings, and conditions
   Rating:
   Low: measure set is limited to select set of providers, care settings, and conditions
   Medium: measure set is applicable to at primary care and specialty providers in a limited set of care settings and conditions
   High: measure set is applicable across multiple types of providers, care settings, and conditions

4. **Measure set avoids undesirable consequences**
   Demonstrated by a measure set in which the measures avoid undesirable consequences or have a method for detecting undesirable consequences
   Rating:
   Low: concern for unintended undesirable consequences and detection would require additional data collection
   Medium: some concern for unintended undesirable consequences which could be detected with additional analysis of existing data (e.g., analysis of patient case mix); or incentives for potential undesirable consequences are balanced within the set of measures (e.g., incentive to drop caring for certain types of patients balanced with incentives to provide care for that same group of patients)
   High: little concern for unintended undesirable consequences; or the set includes measures to detect potential unintended consequences

Table 1: National Quality Strategy Priorities:

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

Table 2: High-Impact Conditions:

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

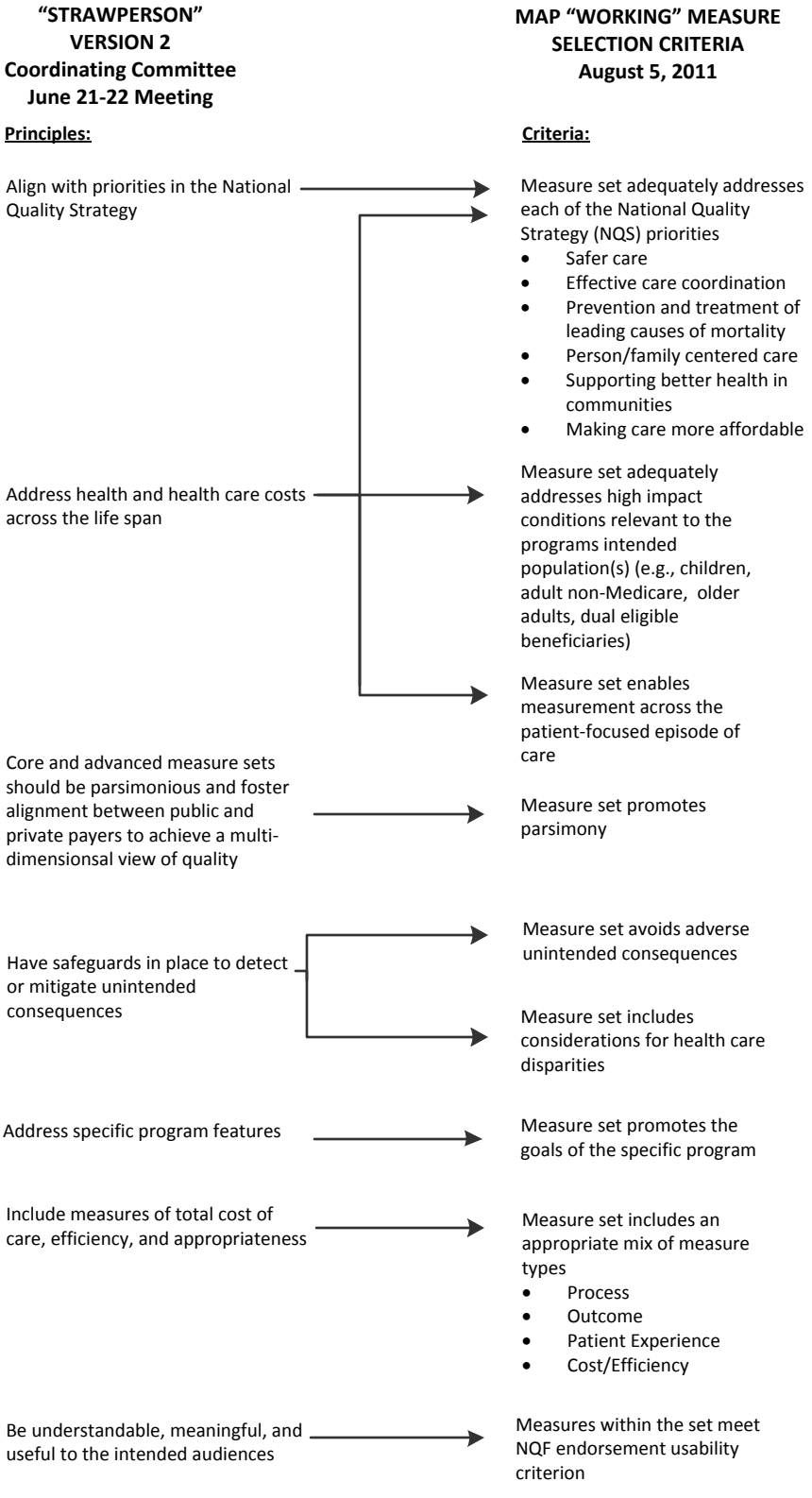
Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese (≥85th percentile BMI for age)
3. Risk of developmental delays or behavioral problems
4. Oral Health
5. Diabetes
6. Asthma
7. Depression

8. Behavior or conduct problems
9. Chronic Ear Infections (3 or more in the past year)
10. Autism, Asperger's, PDD, ASD
11. Developmental delay (diag.)
12. Environmental allergies (hay fever, respiratory or skin allergies)
13. Learning Disability
14. Anxiety problems
15. ADD/ADHD
16. Vision problems not corrected by glasses
17. Bone, joint or muscle problems
18. Migraine headaches
19. Food or digestive allergy
20. Hearing problems
21. Stuttering, stammering or other speech problems
22. Brain injury or concussion
23. Epilepsy or seizure disorder
24. Tourette Syndrome

Appendix 4C

Principles Informing MAP Measure Selection Criteria

Purpose: To develop measure selection criteria for public reporting; payment programs; and program monitoring and evaluation



Mapping of Stanford Input to MAP Measure Selection Criteria

Stanford Input – High Priority Measure Set Selection Criteria	MAP Measure Selection Criteria
Performance classification methods should accompany proposed measure sets to classify performance that is specific to the intended use. The method should demonstrate that performance discrimination is sufficient to yield meaningful results for the user audience	Measures within the set meet NQF endorsement criteria *Measures within the set meet NQF endorsement criteria are determined to be important to measure and report, have scientifically acceptable (i.e., validity and reliability testing) measure properties, usable, and feasible*
Measure sets should capture multiple dimensions of a given quality construct. Use groups of measures that address the same construct, condition, procedure or setting • a. Measure(s) should foster alignment between cost of care and other domains of quality performance. • b. Overuse/appropriateness measures should be included in a balanced measure set.	Measure set adequately addresses each of the National Quality Strategy (NQS) *Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities (Safer care, Effective care coordination, Prevention and treatment of leading causes of mortality, Person and family centered care, Supporting better health in communities, Making care more affordable)*
Outcomes measures are a preferred component of any measure set to ensure that the highest valued performance indicators are deployed – and, in particular, to capture health and cost outcomes across the care system	Measure set includes an appropriate mix of measure types *Demonstrated by a measure set that includes an appropriate mix of process, outcomes, patient experience, and cost/efficiency measures necessary to achieve the goals of the program*
Measure sets for patients whose treatment spans care settings should include continuity of care measures. Measure sets that promote shared accountability by assessing care coordination, team care experiences, and episodes of care that span care settings and integrated care transition processes are preferred	Measure set enables measurement across the patient-focused episode of care *Demonstrated by assessment with the patient as the unit of analysis across providers, settings, and time* Measure set adequately addresses each of the National Quality Strategy (NQS) *Demonstrated by measures addressing each of the National Quality Strategy (NQS) priorities (Effective care coordination)*
Measure aggregation methods should accompany proposed measure sets to ensure performance information can be summarized at a level that is meaningful and useful for the user audience	Measure set promotes the goals of the specific program *Demonstrated by a measure set which is applicable to the intended providers, care settings, and levels of analysis, and population(s) relevant to the program* Measures within the set meet NQF endorsement criteria *Measures within the set meet NQF endorsement criteria are determined to be important to measure and report, have scientifically acceptable measure properties, usable, and feasible*
Methods should be incorporated into the measure set to enable provider participation if the provider is unable to supply data for all measures	Not mapped

NQF
NATIONAL QUALITY FORUM

Measure Applications Partnership
Clinician Workgroup Experience Using the Measure Selection Criteria

The Clinician Workgroup evaluated the proposed measure set for the Physician Value-Based Payment Modifier (Value-Modifier), which was published in the 2012 Medicare Physician Fee Schedule Proposed Rule[i]. The Value-Modifier program was selected for review because it applies to both individual and group levels of analysis and because of its significance as the initial set of measures for the value-modifier program, which will be the first performance-based payment program to be applied to all physicians participating in Medicare.

For this exercise, the Clinician Workgroup used the draft set-level measure selection criteria below that were derived from the Coordinating Committee measure selection criteria principles and the Workgroup's characteristics of an ideal measure set:

1. Measure set provides a comprehensive view of quality – assesses the extent to which a measure set **addresses all of the National Quality Strategy (NQS) priorities** (effective communication and care coordination, person- and family-centered care, making quality care more affordable, enable healthy living, make care safer, prevention and treatment of leading causes of mortality)
2. Measure set provides a comprehensive view of quality – assesses the extent to which a measure set **addresses high-leverage opportunities identified for the intended accountable entities**
3. Measure set is appropriate for all intended accountable entities – assesses the extent to which a measure set is **applicable to the intended providers, care settings, and levels of analysis relevant to the program**
4. Measure set promotes parsimony – assesses the extent to which a measure set supports efficient use of resources for data collection, measurement, and reporting through the **smallest number of measures needed** to address the NQS, high leverage opportunities, and all intended accountable entities
5. Measure set avoids undesirable consequences – assesses the extent to which a measure set **avoids undesirable consequences or has a method for detecting** undesirable consequences
6. Measure set has an appropriate representation of measure types – assesses the extent to which a measure set **includes clinical process, outcomes, patient experience, and cost measures**
7. Measure set includes considerations for healthcare disparities – assesses if a measure set **either includes measures that directly address healthcare disparities or includes measures that have been tested for stratification** (by race, ethnicity, socioeconomic status) at the level of analysis appropriate for the program

The Clinician Workgroup members found the set-level measure selection criteria to be a useful qualitative tool to iteratively assess the adequacy of a measure set for a specific purpose, though the criteria would ideally better ascertain if a set contains the best or right measures to address a given criterion. The Clinician Workgroup provided feedback on their experience using each individual criterion:

- Nearly all measures can loosely address some aspect of the NQS priorities, but it is difficult to determine if a measure set addresses the true goals and intent of the NQS priorities.
- High-leverage should be defined beyond high-impact conditions to capture opportunities for improvement that cross conditions.

- Evaluating if a measure set is appropriate for all intended accountable entities was viewed as important by the group. However, simply including measures that are applicable to all intended accountable entities does not necessarily encourage collaboration and coordination across the system.
- Determining if a measure set meets all of the other criteria in a parsimonious manner was challenging for the group to assess. Evaluation of whether the measure set contains the minimum number of measures necessary requires an understanding of the universe of available measures.
- While it is important to consider if a measure set avoids undesirable consequences, it is difficult to predict as all measures have some potential for unintended consequences. Undesirable consequences may best be addressed through programmatic features, such as monitoring and mitigation strategies.
- Representation of process, outcomes, experience, and cost measures is important. However, appropriate use for the specific program, rather than equal representation of measure types, is the goal. For example, a single experience of care measure may be adequate for a measure set.
- Addressing healthcare disparities should be a priority. This criterion is difficult to assess as it depends on adequacy of risk adjustment or use of stratification, which may not be feasible at the individual clinician level due to sample size.

[i] Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS). *Physician Fee Schedule.* Baltimore, MD: CMS, 2011. Available at: https://www.cms.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1249142. Last accessed August 2011.

MAP "Working" Measure Selection Criteria Tables

Table 1: National Quality Strategy Priorities:

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

Table 2: High-Impact Conditions:

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

Child Health Conditions and Risks
1. Tobacco Use
2. Overweight/Obese ($\geq 85^{th}$ percentile BMI for age)

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

Overview of Federal Clinician Programs

FEDERAL PROGRAMS **IDENTIFYING INFORMATION**	**Physician Quality Reporting System (PQRS)**	**Electronic Health Records (EHR) – Meaningful Use**	**Physician Feedback/Value Modifier**	**Physician Compare**	**E-Prescribing Incentive Program**
Description/Purpose of Program	PQRS provides an incentive payment to eligible professionals who select among 240 measures to report.	The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals for the "meaningful use" of certified EHR technology. To qualify for an incentive payment under the Medicaid EHR Incentive Program, an eligible professional must meet **one** of the following criteria: • Have a minimum 30% Medicaid patient volume* • Have a minimum 20% Medicaid patient volume, and is a pediatrician* • Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals	The Physician Resource Use Measurement and Reporting (RUR) Program, or the Physician Feedback/Value Modifier Program, uses claims data to create confidential reports measuring the resource use and quality of care involved in furnishing care. These feedback reports are provided to medical professionals and medical practice groups.	The Physician Compare Web site serves as a healthcare professional directory on Medicare.gov. The website is updated on a monthly basis. Physician compare can begin incorporating quality reporting in 2013, based on performance starting 2012.	The E-Prescribing Incentive Program provides incentive payments to eligible professionals who are successful electronic prescribers. Eligible professionals report on an electronic prescribing quality measure.
Types of Clinicians Participating	• Physicians (medicine, osteopathy, podiatric med, optometry, surgery, oral surgery, dental med, chiropractic) – *same categories as Medicare EHR/MU and E-Prescribe* • Practitioners including: ➢ Physician Assistant	FOR MEDICARE • Physicians (medicine, osteopathy, podiatric med, optometry, dental surgery/medicine, chiropractor) – *same as PQRS and e-Prescribe* FOR MEDICAID	The 2010 pilot included physicians and medical professional groups.	Clinicians participating in PQRS	• Medicare physicians *(same categories as PQRS and Medicare EHR/MU)* • Practitioners *(same categories as PQRS but not EHR/MU)* • Therapists *(same categories as PQRS but not EHR/MU)* Participation is further limited by

Overview of Federal Clinician Programs

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	➢ Nurse Practitioner ➢ Clinical Nurse Specialist ➢ Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant) ➢ Certified Nurse Midwife ➢ Clinical Social Worker ➢ Clinical Psychologist ➢ Registered Dietician ➢ Nutrition Professional ➢ Audiologists - *Same categories as e-Prescribe but not HER/MU* • Therapists (Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist) – *same categories as e-Prescribe but not EHR/MU*	• Physicians (primarily doctors of medicine and doctors of osteopathy • Nurse practitioner • Dentist • Certified nurse-midwife • Physician assistant practicing in a Federally qualified health center (FQHC) led by a physician assistant or a rural health clinic (RHC), that is so led by a physician assistant.			whether or not the professional has prescribing authority.
Data Reporting/Data Submission (and timing)	Physicians are considered to have "satisfactorily reported" if they meet requirements for number and type of measures, sufficient number/percent of patients, and timeliness of submission. Individual physicians: • Claims based reporting of individual measures *(Select 3 measures from 240 possible,*	Using CMS' web-based Registration and Attestation System, providers complete numerators and denominators for the meaningful use objectives and clinical quality measures, exclusions to specific objectives, and legally attest to the successful demonstration of meaningful use. To qualify for incentive payments, meaningful use requirements must be met in the following	CMS uses claims data to create confidential reports gauging the resources and quality of care utilized in furnishing care to Medicare beneficiaries.	CMS is populating Physician Compare with information from eligible professionals who satisfactorily reported PQRS measures and for successful e-prescribers.	The program ends in 2014, but physicians will receive a penalty for not e-prescribing beginning in 2012. (see **incentive structure** below for more information) *2011eRX Incentive Program* For incentive payment purposes, eligible professionals may submit

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	but note that some measures are restricted to certain reporting mechanisms) • Registry based reporting of individual measures *(Select 3 measures from 240 possible, but see above note – not all 240 available for all reporting mechanisms)* • Claims based reporting of one measure group • Registry based reporting of one measure group • 6-month and 12-month reporting period option • EHR-based reporting for a 12-month period (Select 3 measures) Group practice: For groups with 200 or more eligible professionals, report 26 measures. For groups with 2-199 eligible professionals, report 1-4 measure groups and 3-6 individual measures (# of measures/measure groups depends on size of group)	ways: • **Medicare EHR Incentive Program**— demonstrate meaningful use of certified EHR technology every year of participation. • **Medicaid EHR Incentive Program**— Eligible professionals may qualify for incentive payments if they adopt, implement, upgrade OR demonstrate meaningful use in their first year of participation. They must successfully demonstrate meaningful use for subsequent participation years. For eligible professionals, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met, including: 15 required core objectives & 5 menu set objectives that may be chosen from a list of 10. **Reporting Period:** The reporting period for the EHR Incentive program using a certified EHR is any continuous 90 day period during the first payment year. EPs must report on 6 total measures from the table of 44 clinical quality measures: 3 required			information: 1. To CMS on their Medicare Part B claims, 2. To a qualified registry, 3. To CMS via a qualified electronic health record (EHR) product. For purposes of the 2012 payment adjustment, eligible professionals must submit information on their Medicare Part B claims.

Overview of Federal Clinician Programs

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	Measure rates are calculated by CMS or registries based upon data submitted by the eligible professional or group practice	core measures (substituting alternate core measures where necessary) and 3 additional measures. A maximum of 9 measures would be reported if the EP needed to attest to the 3 required core, the three alternate core, and the 3 additional measures. **Dates/Timelines:** April 18, 2011 - Medicare EHR Incentive Program began February 29, 2012 - last day for EPs to register and attest to receive an Incentive Payment for CY 2011 2016 – last year to receive a Medicare EHR Incentive Payment 2021 – last year to receive a Medicaid EHR Incentive Payment			
Data Sources	• Claims • Registry • EHR • GPRO tool	EHR	Claims data	N/A	Claims data (2009); Registry (2010); EHR (2010)

Overview of Federal Clinician Programs

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Performance Reports to Clinicians (and timing)	Feedback reports are provided to physicians by CMS the summer after the reporting period option which they chose. CMS provides a PQRS feedback report to every eligible professional that attempted to report a PQRS measures at least once during the reporting period regardless of whether an incentive payment was earned.	N/A Once providers complete a successful online attestation submission by entering their data into the Medicare EHR Incentive Program Registration and Attestation System, they will see an immediate summary of their attestation and whether or not it was successful. For the Medicaid EHR Incentive Program, providers will follow a similar process using their state's Attestation System.	Feedback reports include data such as the following: • beneficiary characteristics • practice site • performance measurement results for physician quality • patient chronic conditions • PQRS participation • medical practice group • non-risk adjusted cost measures • risk adjustment model • cost of service categories • utilization statistics • peer groups • benchmarks	N/A	The eRx incentive payments and the eRx feedback reports are issued through separate processes. eRx Incentive Program feedback report availability is not based on whether or not an incentive payment was earned. Feedback reports will be provided to every eligible professional submitting Medicare Part B PFS claims who reported the eRx measure a minimum of once during the reporting period.

Overview of Federal Clinician Programs

FEDERAL PROGRAMS **IDENTIFYING INFORMATION**	**Physician Quality Reporting System (PQRS)**	**Electronic Health Records (EHR) – Meaningful Use**	**Physician Feedback/Value Modifier**	**Physician Compare**	**E-Prescribing Incentive Program**
Public Reporting (and timing)	None at this time. CMS is required to establish a plan for making information available through the Physician Compare Web site by January 1, 2013.	N/A	N/A	The Physician Compare Web site contains information about medical professionals who satisfactorily participated in the PQRS; however, it does not yet include physician and eligible professional performance information. CMS is required to establish a plan for making information available on physician performance through the Physician Compare by January 1, 2013. The reporting period can begin on or after January 1, 2012.	N/A
Incentive Structure	Incentives are in place through 2014 for reporting; penalties for not reporting begin in 2015. According to the ACA, the incentive payment amount for the 2011 reporting period will be 1.0 percent of the total estimated allowed charges. For the periods from 2012 through 2014, the incentive payment will be 0.5 percent. Starting in 2015, eligible professionals who do not satisfactorily report for the reporting period will be subject to a payment adjustment or penalty, by which the PFS amount will decrease by 1.5 percent for 2015 and	**Medicare EHR Incentive Program:** • Participation started January 2011. Attestation opened in April, 2011 and Payments began in May 2011. • Eligible professionals must begin participation by 2012 in order to receive the maximum incentive payment. • Medicare eligible professionals that do not successfully demonstrate meaningful use will have a payment adjustment in their Medicare reimbursement, beginning 2015 and beyond.	CMS is required to include cost and quality data when calculating payments for physicians by applying a value-based payment modifier under the Medicare Physician Fee Schedule (MPFS), which will begin in 2015. By 2017, the value-based payment modifier will be applied to the majority of medical professionals, and ultimately it will be employed for the value-based payment modifier.	N/A	*2011 and 2012 eRX Incentive Program* The incentive will amount to 1.0% of the total estimated allowed charges submitted not later than 2 months after the end of the reporting period. *(aligns with PQRS for 2011 but not for 2012)* *2013 eRX Incentive Program* The incentive amount will be reduced to 0.5%, and starting in 2012, eligible professionals who are

Overview of Federal Clinician Programs

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	2.0 percent for 2016 and every year thereafter.	Incentive payments for the Medicare EHR Incentive Program will be issued within four to six weeks of providers successfully submitting their attestation. **Medicaid EHR Incentive Program:** • States and territories will offer the incentive program on a voluntary basis, which may begin as early as 2011. Payments will be paid by the states and are expected to begin in 2011. • There are no payment adjustments to Medicaid reimbursement if a provider does meet meaningful use beginning 2015. Incentives for the Medicaid EHR Incentive Program will be issued within six weeks of providers successfully submitting their attestation. NOTE: PARTICIPATION MANDATORY UNDER MEDICARE BUT VOLUNTARY UNDER MEDICAID			not successful electronic prescribers may be subject to a payment adjustment or penalty. The PFS amount shall be reduced by 1.0% for 2012, 1.5% for 2013, and 2.0% for 2014. (note: penalties are incurred 3 years sooner than with PQRS)

Appendix 6

Value Based Payment Modifier Measures
(A total of 62)

NQF Measure Number and Status	Measure Name
0028 Endorsed	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
0001 Endorsed	Asthma: Asthma Assessment
0002 Endorsed	Appropriate Testing for Children with Pharyngitis
0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
0012 Endorsed	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
0013 Endorsed	Hypertension: Blood Pressure Measurement
0014 Endorsed	Prenatal Care: Anti-D Immune Globulin
0017 Endorsed	Hypertension (HTN): Plan of Care
0018 Endorsed	Controlling High Blood Pressure
0024 Endorsed	Weight Assessment and Counseling for Children and Adolescents
0031 Endorsed	Preventive Care and Screening: Screening Mammography
0032 Endorsed	Cervical Cancer Screening
0033 Endorsed	Chlamydia Screening for Women
0034 Endorsed	Preventive Care and Screening: Colorectal Cancer Screening
0036 Endorsed	Use of Appropriate Medications for Asthma
0038 Endorsed	Childhood Immunization Status
0041 Endorsed	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
0043 Endorsed	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older
0045 Endorsed	Osteoporosis:Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older
0047 Endorsed	Asthma: Pharmacologic Therapy
0052 Endorsed	Low Back Pain: Use of Imaging Studies
0055 Endorsed	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
0056 Endorsed	Diabetes Mellitus: Foot Exam
0059 Endorsed	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
0061 Endorsed	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
0062 Endorsed	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
0064 Endorsed	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
0066 Endorsed	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)
0067 Endorsed	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
0068 Endorsed	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
0070 Endorsed	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
0073 Endorsed	Ischemic Vascular Disease (IVD): Blood Pressure Management Control
0074 Endorsed	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
0075 Endorsed	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control < 100 mg/dl
0079 Endorsed	Heart Failure: Left Ventricular Function (LVF) Assessment
0081 Endorsed	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0082 Endorsed(to be retired)	Heart Failure: Patient Education
0083 Endorsed	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
0084 Endorsed (to be retired)	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
0085 Endorsed (to be retired)	Heart Failure: Weight Measurement
0086 Endorsed	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
0088 Endorsed	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
0089 Endorsed	Diabetic Retionpathy: Communication with the Physician Managing On-going Diabetes Care
0091 Endorsed	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

Value Based Payment Modifier Measures
(A total of 62)

NQF Measure Number and Status	Measure Name
0097 Endorsed	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility
0101 Endorsed	Falls: Screening for Fall Risk
0102 Endorsed	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
0105 Endorsed	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD
0385 Endorsed	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
0387 Endorsed	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
0389 Endorsed	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up
0555 Endorsed	Monthly INR for Beneficiaries on Warfarin
0575 Endorsed	Diabetes: HbA1c Control < 8%
0729 Endorsed	Diabetes Mellitus: Tobacoo Non-Use
0729 Endorsed	Diabetes: Aspirin Use
NA1	Heart Failure: Left Ventricular Function (LVF) Testing
NA2	30 Day Post Discharge Physician Visit
NA5	Coronary Artery Disease (CAD): LDL level < 100 mg/dl
NA88	Chronic obstructive pulmonary Disease (COPD): smoking cessation counseling received
NA89	Proportion of adults 18 years and older who have had their BP measured within the preceding 2 years
NA90	Preventive Care: Cholesterol-LDL test performed

Note: NA denotes measures that have not been submitted to NQF.