MEASURE APPLICATIONS PARTNERSHIP

Measure Applications Partnership Strategic Plan: 2012–2015

FINAL REPORT

OCTOBER 2012

NATIONAL QUALITY FORUM

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PURPOSE OF THE MAP STRATEGIC PLAN

The American healthcare system is a complex network of healthcare providers, health professionals, purchasers, health plans, government agencies, and the public working to improve health and healthcare. The gap between the actual and ideal health of the population and quality and cost of healthcare services represents a tremendous opportunity for improvement. Performance measures are important tools to monitor and encourage progress on closing the performance gap. Performance measurement results can inform decisions by people who are seeking, purchasing, and providing care. To that end, the Affordable Care Act requires a consensus-based entity to convene multistakeholder groups to provide input on the best performance measures for use in public- and private-sector public reporting and performance-based payment programs; the Measure Applications Partnership (MAP) was convened by the National Quality Forum (NQF) to meet this need.

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

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

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

BACKGROUND

Performance Measurement: History and Emerging Needs

More than 10 years ago, our nation awakened to a sobering reality: our healthcare system, while delivering innovative help and healing, was also generating preventable harm. People were suffering or dying from avoidable mistakes, and our collective bill was growing for services that often generated little value. All the while, we as a nation were experiencing more life-debilitating disease and watching our overall indicators of health decline.

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

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

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

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

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

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

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

MAP's Role

HHS has contracted with NQF, a consensus-based organization, to convene MAP as the body that helps coordinate and provide upstream recommendations on measure use. MAP is a unique collaboration of organizations, designed to balance the interests of consumers, businesses and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. MAP's diverse, public-private nature ensures that future federal strategies and rulemaking with respect to measure selection are informed upstream by varied, thoughtful organizations that are invested in the outcomes of the measurement decisions.

In its first year, MAP provided both program-specific measure recommendations to HHS (first annual MAP Pre-Rulemaking Report) and recommendations for coordination of performance measurement across public- and private-sector programs (see Appendix A for MAP Background). This initial work was a big first step toward achieving a "red, yellow, green" for measurement. It also highlighted that we as a nation have a ways to go.

Recognizing the complexity and importance of MAP's tasks, this strategic plan includes ambitious goals and objectives and deliberate approaches to achieve those goals and objectives over time. In pursuit of its objectives, MAP established several overarching strategies to guide its ongoing and future work. MAP also developed an action plan that delineates concrete tactics for implementing the MAP strategies over the next three years. Initial work on these tactics (e.g., initial development of families of measures) will continue to enhance MAP's input to HHS and other public- and private-sector stakeholders. As MAP evolves, the tactics will also evolve to ensure that the MAP strategies are addressed with increasing sophistication. Public commenters strongly supported the role of MAP in advancing the NQS priorities through the goals, objectives, strategies, and tactics in this plan.

MAP GOAL AND OBJECTIVES

The NQS provides national strategic guidance for providing better care, improving health for people and communities, and making care more affordable. The NQS identifies priorities and goals for rapidly improving health outcomes and increasing the effectiveness of care for all populations.[1] In pursuit of the aims, priorities, and goals of the NQS, MAP provides input on the selection of performance measures to achieve the **goal of improvement, transparency, and value for all**. MAP's objectives are to:

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

1 See www.healthcare.gov/law/resources/reports/nationalqualitystrategy032011.pdf.

MAP STRATEGIES

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

Although MAP's input focuses on HHS quality improvement programs, MAP recognizes that aligned performance measurement is important to send clear direction and provide strong incentives to providers and clinicians regarding desired health system change. Accordingly, MAP will **promote alignment of performance measurement across HHS programs and between public- and private-sector initiatives**. Strategically aligning

public and private payment and public reporting programs (across settings, programs, populations, and payers) will encourage delivery of patient-centered care, reduce providers' data collection burden, and provide a comprehensive picture of quality.

MAP aims to **ensure that recommended performance measures are high-impact, relevant, actionable, and drive toward realization of the NQS**. NQF endorsement, as an initial consideration for measure selection, ensures that measures that are important, scientifically acceptable, feasible, and useful for accountability purposes and quality improvement. Through its consensus-driven process, MAP then utilizes its Measure Selection Criteria to recommend measures that are high-leverage opportunities for improvement, align with the NQS, promote alignment across programs, and consider the needs of complex patients. MAP has adopted a person-centered approach to measurement, preferring measures of patient outcomes (or those processes most tightly linked to outcomes) and experience across settings,[2] rather than measures that are specific to providers or settings. Performance measurement is continually evolving, and many of the performance measurement programs for which MAP provides input are long established and may include measures that are topped out, do not drive improvement in patient outcomes, or result in unintended consequences of measurement. Accordingly, MAP will **recommend removal of measures from federal programs that no longer meet program needs.**

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

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

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

2 One commenter noted that MAP's person-centered approach to measure selection should consider the needs of the most vulnerable patients who may not be able to participate in patient-reported outcomes and experience surveys.

TABLE 1. MAP GOALS, OBJECTIVES, STRATEGIES, AND TACTICS

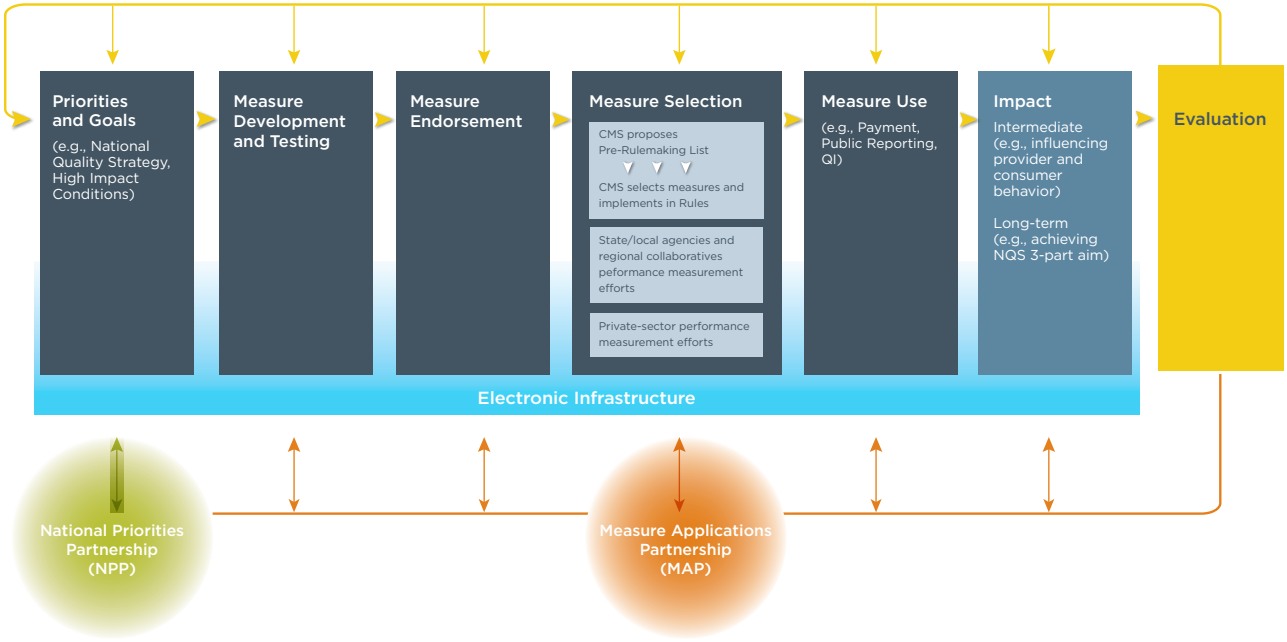
Goals:	Objectives	Strategies	Tactics (see MAP Action Plan below for further detail)	Milestones/Metrics of Success
Achieve improvement, transparency, and value, in pursuit of the aims, priorities, and goals of the National Quality Strategy	1. **Improve outcomes in high-leverage areas for patients and their families (i.e., progress toward realization of the NQS)**	• Ensure that recommended performance measures are high-impact, relevant, actionable, and drive toward realization of the NQS • Establish feedback loops to support a data-driven approach to MAP's decision-making and build on other initiatives (e.g., NQS, NPP, private-sector efforts) • Provide input on measure sets for numerous accountability applications	• Identify Families of Measures and Core Measure Sets (see page 15) • Refine the MAP Measure Selection Criteria (see page 24) • Develop Analytic Support for MAP Decision-Making (see page 21) • Define Measure Implementation Phasing Strategies (see page 20) • Evaluate MAP's Processes and Impact (see page 25)	• Program measure sets (public- and private-sector programs) align with MAP families of measures and core measure sets
	2. **Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy on value**	• Promote alignment of performance measurement across HHS programs and between public- and private-sector initiatives • Stimulate gap-filling for high-priority measure gaps • Identify solutions to performance measurement implementation barriers	• Identify Families of Measures and Core Measure Sets • Address Measure Gaps (see page 18) • Refine the MAP Measure Selection Criteria • Evaluate MAP's Processes and Impact	• Funding for measure development and developer efforts focus on the highly prioritized gaps identified by MAP • Proposed solutions to implementation barriers for existing high-leverage measures are tested in the field • Low-value measures are removed from programs
	3. **Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burde**n	• Establish feedback loops to ensure that MAP's recommendations are relevant to public and private implementers and that its processes are effective • Establish feedback loops to determine whether MAP's recommendations are meeting stakeholder needs and are aligned with their goals • Recommend removal of low-value measures from federal programs	• Identify Families of Measures and Core Measure Sets • Refine the MAP Measure Selection Criteria • Establish a MAP Communication Plan (see page 28) • Execute MAP's Approach to Stakeholder Engagement (see page 13)	• Key stakeholders are aware of and engaged in MAP work • MAP recommendations are implemented in public- and private-sector programs

Feedback Loops

The MAP strategies highlight the need for multi-directional collaboration among the many local, state, and national stakeholders in the public and private sectors engaged in performance measurement efforts to achieve the NQS goals.

These efforts comprise the quality enterprise and include the functions of priority and goal setting, measure development and testing, measure endorsement, measure selection and use for various purposes, and determining impact. Figure 1 demonstrates the complex interactions among the functions and those entities fulfilling the functions.

FIGURE 1. THE QUALITY ENTERPRISE



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

Priorities and Goals. The NQS priorities and goals serve as a guiding framework for the quality enterprise, including MAP's work. To ensure that its recommendations align with the NQS, MAP will work with the National Priorities Partnership (NPP) and other entities to understand the implications of the NQS priorities and goals and what quality measures are needed for which purposes. As MAP develops recommendations, it may identify opportunities to enhance the NQS, and it will collaborate with its federal partners and NPP to determine how to address these opportunities in the work of the MAP and NPP.

Measure Development and Testing. Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., AMA-convened PCPI, NCQA, The Joint Commission, medical specialty societies). Throughout its work, MAP identifies and prioritizes measure gaps. To effectively assist in

addressing measure gaps, MAP needs information about measures in the development pipeline to understand which high-leverage improvement opportunities remain unaddressed. Further, to help identify solutions, MAP needs a deep understanding of the barriers that hinder measure development (e.g., unreliable or unavailable data sources). MAP will reach out to measure developers to gather and provide information regarding measure gaps.

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

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

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

Evaluation. As MAP garners additional information by establishing feedback loops, its processes will continue to evolve. MAP's evaluation efforts must solicit feedback from stakeholders across the quality enterprise on an ongoing basis to determine whether MAP is successful.

Public commenters agreed that feedback loops are essential for creating timely and meaningful collaboration with a broad set of stakeholders, and they encouraged MAP to leverage existing resources and feedback loops (e.g., CMS national provider calls to discuss measures, NQF measure endorsement maintenance process) to increase efficiency of MAP processes.

Table 2 provides an initial mapping of the collaboration needed, captured in the context of inputs to and outputs of MAP's work. MAP outputs reflect MAP's planned deliverables, which are further described in the MAP Action Plan.

TABLE 2. MAP FEEDBACK LOOPS ACROSS THE FUNCTIONS OF THE QUALITY ENTERPRISE

Function of the Quality Enterprise	MAP Needed Inputs		MAP Outputs	
	Information	Key Stakeholders	Information	Key Stakeholders
Priorities and Goals	• NQS priorities and goals • Priorities and goals of entities outside of the federal government • Adoption of the NQS (by federal agencies, state and local agencies, private-sector initiatives) and rationale	• NPP (multi-stakeholder group including, but not limited to, clinicians, providers, consumers, purchasers, health plans, measurement experts, accreditation/ certification organizations) • Federal partners (e.g., AHRQ, CMS, ONC, SAMHSA, HRSA, VA, DoD) • State/local agencies, regional collaboratives	• Identify where national strategies or action plans are needed (e.g., disparities) • Signals where state and local innovation can inform national strategies	• NPP • Federal partners • State/local agencies, regional collaboratives
Measure Development and Testing	• Measures in the development pipeline • Development issues—evidence base, data for testing	• Measure developers (e.g., AMA-PCPI, NCQA, The Joint Commission, medical specialty societies, regional collaboratives) • NQF endorsement process (i.e., Consensus Standards Approval Committee, topic-specific Steering Committees)	• Identification and prioritization of gaps • Identification of gap-filling barriers	• Measure developers • NPP • NQF endorsement process • Federal partners (e.g., CMS, AHRQ, ONC, SAMHSA, HRSA, VA) • Private sector stakeholders funding measure development (e.g., medical specialty societies and certification boards)
Measure Endorsement	• Endorsed measures—important, scientifically acceptable, feasible, usable • Measures not endorsed— signal where gap-filling has been attempted • Implementation challenges from maintenance process	• NQF consensus development committees (multi-stakeholder groups including, but not limited to, clinicians, providers, consumers, purchasers, health plans, measurement experts)	• Identification and prioritization of gaps • Identification of gap-filling barriers • Solutions to implementation and use barriers	• NQF consensus development committees • Measure developers • Federal partners (e.g., CMS, AHRQ, ONC, SAMHSA, HRSA) • Private-sector stakeholders funding measure development
Measure Selection	• Current measures selected for use in public- and private-sector programs and rationale • Rationale for accepting/rejecting MAP input	• Federal partners • State/local agencies, regional collaboratives • Purchasers, payers (e.g., health insurance plans) • Providers, clinicians • Accreditation/ certification entities • Other public reporting entities (e.g., Consumer Reports, health insurance exchanges)	• Families of measures and core measure sets • Input on measures for specific programs (e.g., adding/removing measures) • Guidance on implementing MAP recommendations	• Federal partners • State/local agencies, regional collaborative • Purchasers, payers • Providers, clinicians • Accreditation/ certification entities • Other public reporting entities

Function of the Quality Enterprise	MAP Needed Inputs		MAP Outputs	
	Information	Key Stakeholders	Information	Key Stakeholders
Measure Use	• Current measures in use, including rationale	• Consumers/patients • Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Accreditation/ certification entities • Providers, clinicians • Assessments of measure use (e.g., CMS, QASC, AHIP, RWJF, NRHI)	• Measure use for varying payment models (e.g., measure domain weighting, benefit structure) • Input on programmatic structure (e.g., data collection and transmission, attribution methods) • Measure use for accountability • Measure use to support clinical quality improvement • Measure use to support informed choices	• Consumers/patients • Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Accreditation/ certification entities • Providers, clinicians
Impact	• Current performance • Improvement or change over time • Unintended Consequences • Outcomes • Usefulness of measurement results	• Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Providers, clinicians • Others who assess measure impact (e.g., CMS, QASC, AHIP)	• Enhance and revise MAP's recommendations and processes	• Federal partners • State/local agencies, regional collaborative • Purchasers, payers • Providers, clinicians • Accreditation/ certification entities • Other public reporting entities
Evaluation	• Definitions of MAP's success	• Consumers/patients • Federal partners • State/local agencies, regional collaboratives • Purchasers, payers • Providers, clinicians • Accreditation/ certification entities	• Enhance and revise MAP's recommendations and processes	• Federal partners • State/local agencies, regional collaborative • Purchasers, payers • Providers, clinicians • Accreditation/ certification entities • Other public reporting entities

HOW CAN STAKEHOLDERS PARTICIPATE IN MAP?

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

If you are a...

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

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

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

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

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

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

MAP ACTION PLAN

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

1. Approach to Stakeholder Engagement

MAP has articulated the need to collaborate with multiple stakeholders across the quality enterprise to support informed decision-making and to determine if MAP recommendations are meeting stakeholder needs. Accordingly, engagement must occur: (1) within MAP as a group, in that MAP members must bring their breadth of experiences and knowledge to allow for more informed decision-making and work to execute MAP's recommendations; (2) with targeted individual stakeholders, to ensure that MAP's recommendations are meaningful and reflect the perspectives and needs of stakeholders; and (3) more broadly with stakeholders involved in some aspect of healthcare quality measurement to determine the degree of uptake and use of MAP recommendations and related supporting materials. Public commenters support MAP's efforts to reach a broader range of stakeholders and suggested that MAP membership be expanded to include additional direct participants (e.g., additional clinician representatives, additional pharmaceutical and pharmacy representatives).

MAP has an annual appointment process, with one-third of its membership up for reconsideration each year. MAP membership is anticipated to further diversify as stakeholders not historically involved with MAP become involved and submit nominations for membership.

Successful engagement depends on MAP members sharing expertise and learning, and using MAP's recommendations. Success also depends on actively engaging the end users (e.g., CMS, private sector) of MAP recommendations, because improvement in outcomes, alignment of measurement, and coordination across programs relies on public- and private-sector stakeholders at the national, state, and local levels applying MAP's recommendations to their own activities. MAP's approach to stakeholder engagement will establish feedback loops (discussed earlier, see Table 2) with multiple stakeholders in phases: an initial engagement phase to frame the approach and make targeted connections, and a subsequent phase defined by a MAP Engagement Task Force. Additionally, the MAP Communications Plan (see page 28) will support the engagement of key stakeholders.

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

TABLE 3. ILLUSTRATIVE EXAMPLE OF MAP'S INITIAL ENGAGEMENT ACTIVITIES.

Overarching Strategy	Action by MAP	Action by MAP Members and Other Stakeholders	Desired Result
Establish feedback loops to support informed decision-making *by MAP as a group*	Identify or create methods to *request and receive insights* from stakeholders to then factor into MAP work. Potential methods may include surveys, web links, workgroup meeting assignments, etc.	Provide comments or insights regarding issues that are important to the quality enterprise	MAP's deliverables reflect stakeholder priorities and perspectives and help meet key practical needs of those directly involved in measurement and improvement of health and healthcare
Establish feedback loops to support informed decision-making *by stakeholders*	Identify or create methods to *share insights and ideas* with stakeholders. Potential methods may include website materials, the NPP Action registry, materials for distribution by MAP members, etc.	Help disseminate insights and ideas from MAP to others involved in measurement and improvement of health and healthcare Apply insights and ideas from MAP in their own work in measurement and improvement of health and healthcare	MAP output motivates and enables stakeholders to take actions that improve outcomes and align measurement across programs and sectors

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

MAP's initial engagement efforts have included soliciting input from MAP members to inform the development of families of measures—collaborating with payers, purchasers, and measure developers to determine where measures are used in public- and private-sector efforts, identifying measure gaps, and understanding potential barriers to addressing measure gaps.

Additionally, MAP has begun bi-directional communication with stakeholders engaged in understanding measure use, ensuring that the results of these efforts will rapidly be available to MAP. For example, MAP has coordinated with America's Health Insurance Plans (AHIP) about its survey of measure use by health plans, the Quality Alliance Steering Committee (QASC) about its environmental scan of measure use, and the Centers for Medicare and Medicaid Services (CMS) about its measure impact evaluation. Finally, MAP will solicit feedback from stakeholders about their experiences with measures (e.g., usefulness, implementation issues); MAP's webpage will provide guidance on submitting information.

MAP Engagement Task Force. MAP would like to expand its reach to a broader range of stakeholders with a goal of engaging those who have not typically participated in MAP processes to this point (e.g., state and local agencies, additional regional collaboratives). MAP will establish a systematic framework for creating and maintaining the bi-directional flow of information and motivating uptake of MAP recommendations, as described above. To accomplish this, MAP

will establish an Engagement Task Force, which will first assess the information types (e.g., measure use, measure performance over time) identified in the feedback loops and analytics sections of this strategic plan to identify possible additional channels for engagement. Methods to be employed may include focus groups, surveys, online discussion forums, regular submission of information by key stakeholders, targeted outreach, as well as options identified through the structured assessment of the communications and outreach capabilities of MAP members. The engagement task force will also determine the most useful content and format for dissemination materials, with a particular focus on meeting various stakeholders' needs to enable and support their uptake of MAP's recommendations. One public commenter noted its willingness to review MAP's materials to ensure they are user-friendly for various audiences.

Action Plan

Collaborators (Who are the key participants?). MAP will engage multiple stakeholders to both inform and disseminate its recommendations to promote uptake and ultimately realize improved outcomes, aligned measurement, and coordinated program efforts. In addition to implementing initial engagement activities, MAP will convene a multi-stakeholder Engagement Task Force, comprising MAP and NPP members to design a framework as the basis for a structured and systematic approach to stakeholder engagement. This task force will provide input to the MAP Coordinating Committee on needed information, methods for obtaining that information, and opportunities for dissemination to promote and support uptake of MAP's recommendations.

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

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

2. Identifying Families of Measures and Core Measure Sets

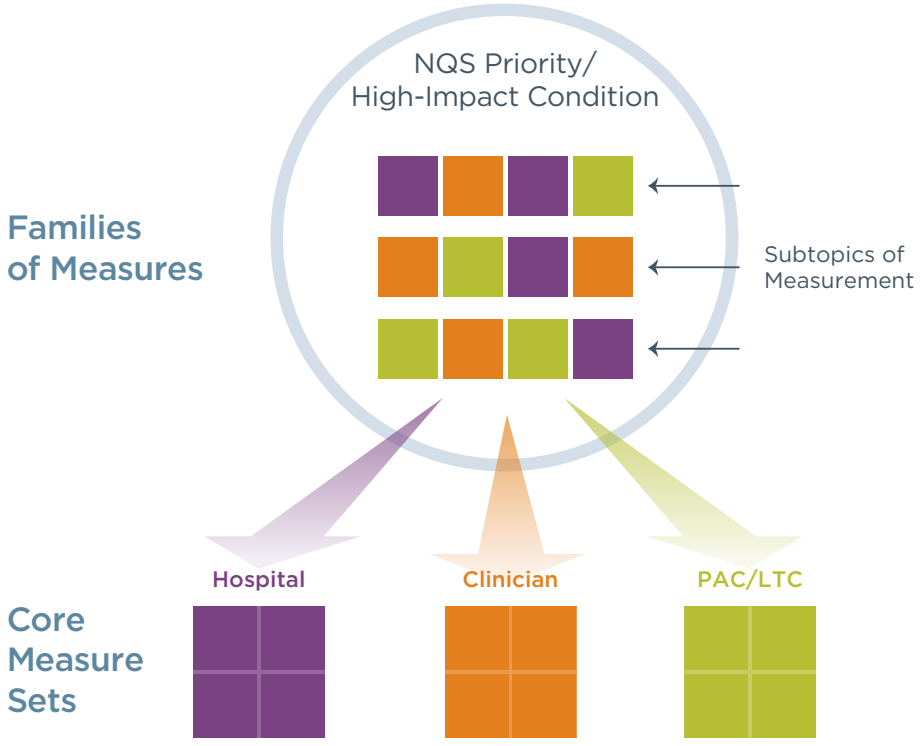
To make progress toward improved outcomes, consistent and meaningful information, and coordination of measurement efforts, MAP seeks to align performance measurement across HHS programs and between the public and private sectors, while identifying the best available measures to use for specific purposes. As a primary tactic to accomplish the objectives, MAP will identify families of measures to promote measure alignment and will create core measure sets to encourage best use of available measures in specific HHS and private-sector programs. The families of measures and core measure sets will serve as a signal to HHS and the field of MAP's highest priorities for measurement for each topic. Although MAP's annual pre-rulemaking input to HHS is not limited to measures identified in the family, the families of measures serve as a starting place and guide for deliberations.

Families of measures are sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities and high-impact conditions. To identify a family of measures, MAP will first ascertain and prioritize the subtopics of measurement that are considered the highest-leverage opportunities

for improvement within a topic. Starting with the strategic opportunities and national-level measures presented in the NQS 2012 Annual Progress Report, MAP will review impact, improvability, and inclusiveness of improvement opportunities under each subtopic, giving additional consideration to cost of care—including areas of waste, inefficiency, and overuse—and disparities to further prioritize the subtopics. Additionally, MAP will consider the highest-leverage improvement opportunities across the lifespan, recognizing that measurement opportunities can vary by age. Next, MAP will review the available measures that address the high-leverage improvement opportunities, gathered from the NQF-endorsed® portfolio of measures, measures used in federal programs and measures used in private-sector efforts, which may include nonendorsed measures that could reasonably meet endorsement criteria.

Using the MAP Measure Selection Criteria to provide guidance for considering if the family addresses the relevant care settings, populations, and levels of analysis, MAP will select measures for inclusion in a family. MAP will actively draw information and seek insights from private- and public-sector efforts; for example, the HHS Interagency Working Group on Healthcare Quality is working to align and coordinate performance measurement across federal programs. MAP will consider measures used in initiatives, such as Partnership for Patients, the Million Hearts Campaign, and private-sector programs (e.g., eValue8, IHA P4P, Bridges to Excellence, health plan value-based purchasing programs). As part of the selection process, MAP will identify the high-leverage opportunities that lack appropriate performance measures as measurement gaps. Figure 2 represents the concept of families of measures.

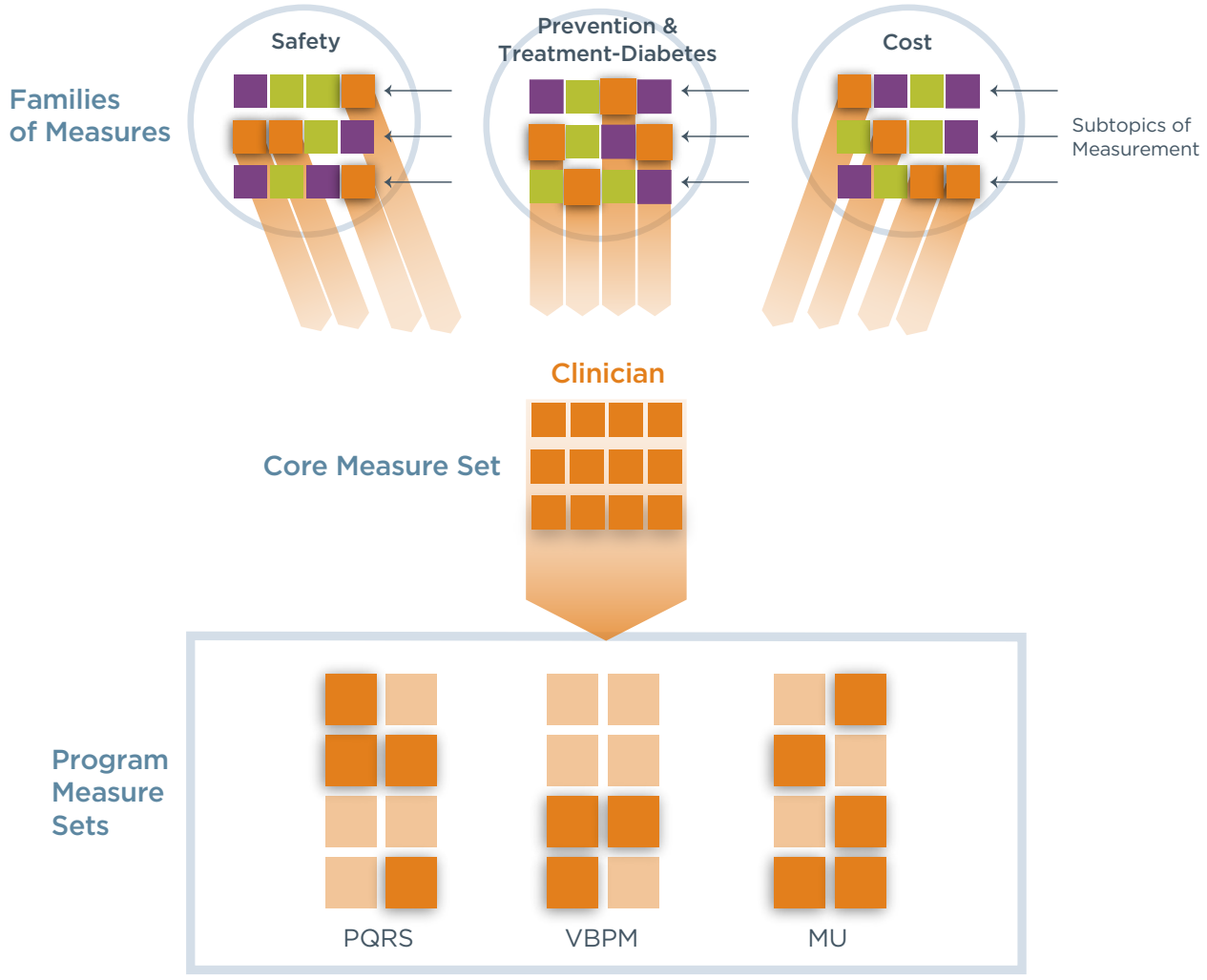
FIGURE 2. FAMILIES OF MEASURES AND CORE MEASURE SETS



Core measure sets are drawn from the families of measures and consist of the best available measures and gaps for a specified care setting, population, or level of analysis. MAP will use the core measure sets to guide its pre-rulemaking input on the selection of measure sets for specific programs, providing recommendations on how program measures sets can best align with the core set. Although MAP's pre-rulemaking input is not necessarily limited to measures from core measure sets, such measures should be viewed as representing the highest-leverage opportunities for priorities areas under the NQS. For additional information on the families of measures, please see the MAP Families of Measures report.

Figure 3 illustrates how core measure sets and program measure sets are populated from families of measures. The boxes represent individual performance measures. In this example, the orange boxes represent measures that are specified for individual clinician or group practice levels of analysis. The dark orange boxes in the clinician program measure sets (i.e., PQRS, Value Based Payment Modifier, Meaningful Use) represent measures recommended for those programs from the clinician core measure set; the light orange boxes in the clinician program measure sets represent measures recommended for those programs that are not included in the clinician core measure set but fit the specific purpose of the program.

FIGURE 3. FAMILIES OF MEASURES POPULATING A CORE MEASURE SET AND PROGRAM MEASURE SETS



Action Plan

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

Deliverables. Through a phased approach, MAP will identify families of measures for each NQS priority and several high-impact conditions (i.e., diabetes, cardiovascular disease, mental health). MAP will revisit and refine the families of measures as needed; for example, if the MAP Measure Selection Criteria are enhanced to include criteria for differing program purposes, then MAP will revisit existing measure families considering the enhanced measure selection criteria. MAP may also identify families of measures to address additional high-impact conditions.

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

3. Addressing Measure Gaps

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

MAP will serve as a catalyzing agent for coordinated gap-filling among public and private entities, engaging measure developers and those organizations that fund measure development by: (1) identifying gaps where measures are not available or inadequately assess performance, (2) prioritizing the gaps by importance and feasibility, (3) presenting measure ideas to spur development, and (4) highlighting barriers to gap-filling and potential solutions to the barriers. Recognizing MAP will not itself resolve measure gaps, given that MAP neither develops nor implements measures, MAP will also identify the key stakeholders (e.g., measure developers) most aptly positioned to fill the measure gaps and collaborate on the development of gap-filling pathways. Public commenters emphasized that the funding needed to develop, test, endorse, and maintain measures is the most significant barrier to gap-filling. 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. MAP will alert key stakeholders about MAP's prioritized gaps, while NPP can assist in coordination with key stakeholders across the quality enterprise to lay out systematic plans to fill gaps.

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

First, high-leverage opportunities for measurement

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

Once measure development and testing have been completed, the measure can be brought forward for endorsement, the seventh step, to be assessed against the endorsement criteria of importance, scientific acceptability, usability, and feasibility. Where endorsed measures are available but not yet implemented or used in appropriate programs, an implementation gap is identified, which is the eighth step. As MAP considers measures for specific programs, it may also identify measure gaps in areas where the currently available NQF-endorsed measures do not adequately meet the program purpose. Evaluation of measure use and impact is the ninth step in the measure lifecycle. Evaluation is important to determine the extent to which a measure is driving intended improvement or unintended, undesirable consequences. Information about the impact of measures is important to support and assess MAP decision-making (see analytics and evaluation sections).

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

FIGURE 4. MEASURE LIFECYCLE

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

Action Plan

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

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

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

4. Defining Measure Implementation Phasing Strategies

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

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

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

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

been finalized for the program.

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

Public commenters supported these more granular categories for making MAP's recommendations clearer and more actionable.

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

Action Plan

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

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

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

5. Analytic Support for MAP Decision-Making

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

- Build on the NQS and broader evidence to identify high-leverage opportunities for improvement;
- Utilize measurement information, including available information on measure use and impact; and
- Inform MAP's evaluation and refine MAP's decision-making framework over time.

Build on the NQS and broader evidence to identify high-leverage opportunities for improvement. The NQS is the foundation for MAP's decision-making. Accordingly, MAP's analytics plan incorporates NPP's input to HHS regarding strategic opportunities and national-level measures to achieve the aims, priorities, and specific goals of the NQS. MAP and NPP will collaborate to ensure that MAP's decisions align with the true intent of the NQS aims and priorities. In addition, MAP will leverage findings from other

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

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

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

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

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

TABLE 4. INFORMATION NEEDED TO SUPPORT MAP DECISION-MAKING

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

Action Plan

Collaborators. MAP will seek input from NPP co-chairs serving on the MAP Strategy Task Force and NPP liaisons to the MAP task forces to identify the high-leverage opportunities for improvement and associated priorities for measurement. To collect information on measure use and impact, MAP will reach out to the NQF membership councils representing more than 450 organizations, as well as to additional stakeholders who are implementing and evaluating performance measures. To supplement its work, MAP will engage in and review the results of research conducted by other entities, such as CMS, AHRQ, QASC, AHIP, and IOM. For examples of potential stakeholders, please refer to Tables 2 and 4.

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

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

6. Refining the MAP Measure Selection Criteria

The MAP Measure Selection Criteria (MSC) guide MAP's input on the selection of measures and identification of measure gaps. The MAP selection criteria are meant to build on, not duplicate, the NQF-endorsement process, including maintenance of endorsed measures. Using the MSC as a guide when selecting measures for families or program measure sets, MAP ascertains whether the measures address relevant care settings, populations, and levels of analysis; are harmonized across settings, populations, and levels of analysis; include appropriate types of measures, including outcome, process, structure, and patient experience measures; and are parsimonious, containing the most important measures for driving change (see Appendix B for MAP Measure Selection Criteria and Interpretive Guide).

MAP envisions that the MSC will evolve as MAP gains experience using the criteria. Over time, MAP will revisit the selection criteria to ensure that its goals and objectives are clearly articulated within the criteria and address issues raised. Planned enhancements to the MSC may include:

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

Addressing fit for different programmatic purposes. MAP provides input on programs that use measurement for multiple purposes (e.g., public reporting, performance-based payment, clinical quality improvement) and that attribute measurement results to varying levels of analysis (e.g., individual clinicians, multidisciplinary teams, systems, communities). After its first year of pre-rulemaking input, MAP concluded that different programmatic purposes may require selection of different measures. For example, measures that are used in public reporting for use by consumers and purchasers must be relevant to audiences without a medical training, as well as be important to providers/clinicians and those who implement public reporting programs. MAP will explore how the MSC could be revised to address attribution at varying levels of analysis and to identify measures best suited for different programmatic purposes. Public commenters supported enhancing the measure selection criteria to consider fit for different programmatic purposes and requested that MAP consider alignment of measure attribution with programmatic structure. One commenter suggested that Home and Community Based Settings, especially home care/personal

care assistance, be recognized in the MSC as a post-acute care/long-term care setting.

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

Adding measure removal criteria. The families of measures and core measure sets establish the ideal. As program measure sets progress toward the ideal, measures that are determined to be less desirable (i.e., measures that are topped out, do not support parsimony, have implementation issues, result in unintended consequences) should be removed from programs to reduce data burden and to avoid misdirection of provider improvement efforts. For example, removal criteria may include removing a measure that has lost NQF endorsement or has been placed in reserve status. Accordingly, MAP will develop criteria for removal of low-value measures, taking into account existing removal criteria (e.g., CMS' removal criteria). One public commenter suggested that the criteria for removal consider changes to the evidence base, topping out, impact, and the cost and burden of collecting and reporting measures relative to benefit.

Action Plan

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

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

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

7. Evaluating MAP's Processes and Impact

Periodic evaluation will gauge the effectiveness of MAP's processes and recommendations and determine whether MAP is meeting stakeholder needs. Evaluation also serves as an opportunity to inform and enhance MAP's subsequent decision-making, including MAP's recommendations regarding families of measures and program measure sets. Further, evaluation will extend to the tools MAP uses to support decision-making, including the MSC and analytics.

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

Short-term evaluation. MAP's ongoing evaluation focuses on determining the uptake of MAP's

recommendations and related support materials to inform future MAP's decision-making. As an initial step, MAP will determine the concordance of its recommendations with the measures proposed and finalized through HHS rulemaking for use in federal programs. MAP will conduct outreach (as part of its overall engagement plan) to other stakeholders selecting measures for use in state, regional, and private reporting programs to determine their needs as end users, their uptake of MAP's recommendations, their rationale for concordance or discordance with MAP's recommendations, and preliminary evidence regarding whether desired outcomes are being achieved. MAP will collaborate with NPP to leverage input from the broad NPP network of performance measurement end users.

Long-term evaluation. A long-term evaluation strategy is needed to assess MAP's impact over time. MAP will initiate an independent third-party evaluation to determine whether MAP is meeting its objectives. The initial phase of the evaluation will build on the milestones and metrics of success established by MAP, to determine the evaluation logic model, research questions, and evaluation protocol. The evaluation protocol will describe data collection (i.e., surveys, key informant interviews, case studies, focus groups) and data analysis methodologies.

Action Plan

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

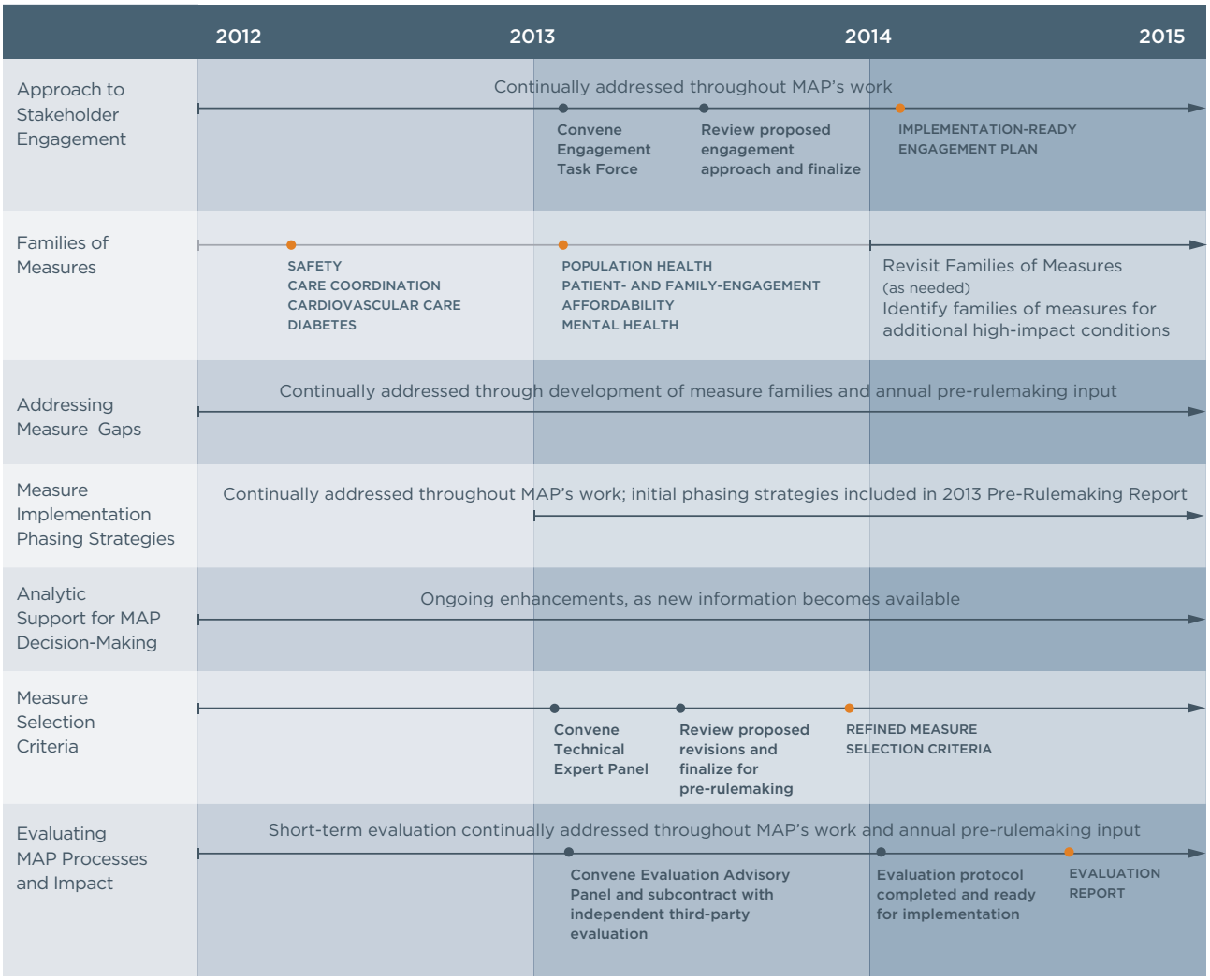
Deliverables. MAP will analyze and report on the uptake of MAP's recommendations in its annual Pre-Rulemaking Report. MAP will also produce a report of the long-term evaluation findings.

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

MAP THREE-YEAR TIMELINE

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

FIGURE 5. MAP GANTT CHART



MAP COMMUNICATIONS PLAN

Overview

It has been a little more than a year since its inception, and the Measure Applications Partnership (MAP) has succeeded in delivering on its **major deliverables** and year-one objectives. The primary audience in year one was a federal audience, as reflected in the multiple coordination strategy reports and MAP's first-ever Pre-Rulemaking Report delivered to HHS on February 1, 2012. A strong foundation for MAP's work has been built, thanks to its partners and many contributors to date.

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

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

Strategy

The exercise of creating a three-year strategic plan for MAP has emphasized the necessity for two-way engagement between MAP and public and private stakeholders. MAP is designed in such a way that its outputs reflect inputs from stakeholders. This message is important to stress over the course of communications activities and will guide efforts to prioritize communications (i.e., focus on tactics that will help stimulate stronger engagement).

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

An important aspect of this plan is the need to participate in feedback loops—bi-directional information sharing between MAP and its stakeholders—which are designed to meaningfully and consistently maintain the flow of information into and out of MAP.

This communications plan lays out a set of recommended activities by year, with specific focus on the first year. Tactics for subsequent years will necessarily evolve based on the needs of the programs and available funding. It is important to note that some, but not all, communications activities are funded under the current MAP scope of work. Certain activities included in the communications and engagement plans may require additional sponsorship, either from a MAP member or a to-be-determined funder.

Target Audiences

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

The goals for reaching these audiences include:

- increasing awareness of the problems MAP is trying to help solve;
- providing greater clarity of the value of MAP work to both the public and private sector—specifically those who provide, pay for, and receive healthcare services;
- improving stakeholder engagement by increasing awareness of new or enhancing existing feedback loops; and
- increasing motivation to participate in the MAP process, as evidenced by more comments submitted, participation in MAP convenings, etc.

Importantly, the notion of "direct to consumer" has been raised during MAP strategy task force meetings. This plan seeks to clarify that MAP is not currently resourced or positioned to launch a direct-to-consumer awareness and education campaign—nor is this an advisable next step relative to supporting the stakeholder engagement work to create or enhance existing feedback loops. That said, the consumer perspective is integral to achieving a culture of measurement that is patient-centric and generates information that helps consumers make informed health and healthcare choices. The MAP communication plan recognizes the power of consumer advocacy organizations to assist with these efforts.

Messaging

MAP messaging can be developed centrally, but to be effective, the key messages should be carried forward by a wide variety of messengers that have reach far beyond those who sit around the MAP table. The potential messengers include MAP members; members of other NQF initiatives, such as the NPP and Endorsement Steering Committees; NQF members through the Council structure; and NQF staff. MAP members in particular have an important role to play in advancing this plan, owning its progress, and helping to refine its approach as the work evolves. Core messages include:

- The healthcare system must improve, especially to provide better care at a lower cost that improves the health of individuals and communities. Understanding how 'healthcare is doing'—by measuring performance using performance measures—helps everyone see where improvement is needed and take action to get better results.
- We each have a role in making informed decisions using performance measurement information, including doctors, hospitals and other care providers, patients and families, employers and other purchasers, health plans, and government. Without such measurement, people are left to make decisions based on hunches or intuition—and we need more than that to improve health and healthcare.
- To help everyone make better decisions about performance measurement, a new group called the Measure Applications Partnership (MAP) brings people together to recommend the best measures to use in public and private programs. This way, program requirements and payments that reward improvement are coordinated to get more value, faster.
- MAP's success hinges on everyone's involvement and ideas to ensure the best possible recommendations.

Tactics

To successfully accomplish this plan's goals, several internal (NQF-staff driven) and external (the entire group of messengers) tasks must be accomplished. Although they will evolve over the course of three years, these tasks will maintain the basic principle of promoting two-way engagement.

Year One

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

GOAL: BUILD A FOUNDATION

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

MATERIALS (PROVIDED BY NQF)

- One-pager describing MAP and its function
- Core set of PowerPoint slides outlining the basics of MAP
- Short versions of all MAP materials, presented in ways that comply with plain language principles (see www.plainlanguage.gov)
- Tough-questions guide for internal use
- Frequently asked questions guide for external use—geared around plain language explanations, how to effectively get involved, and what is at stake
- Messaging guide for internal use by members of MAP and other key messengers
- Template newsletter articles providing descriptions of MAP, updates on recent reports, and information about feedback loops
- Infographic illustrating what MAP is and how it relates to other work being done at NQF and with other NQF-convened groups
- Infographic illustrating how MAP fits with and relates to external work being done by QASC, AHRQ, NCQA, and others
- "Making connections" documents, explaining how the work of individual groups within NQF (MAP, NPP, other NQF-affiliated stakeholder groups) connects and informs the work of other groups. This can be accomplished with a voiced-over PowerPoint deck, pictorials, and other fact sheets.
- Digital toolbox to contain all important materials—one-pagers, fact sheets, reports, PowerPoint slides, etc.—allowing for centralized repository of materials that can be de-centrally tailored and distributed
- Continued build-out of NQF's MAP web presence, with explicit links to places within NQF that feedback can be provided such as the Quality Positioning System, the new under-development NPP Action Registry, etc.
- Plan for outreach to all NQF Councils, tailored to each group
- Inventory of MAP partner communications assets, starting with the coordinating committee, and later creating specialized inventories based on work groups and subject matter experts

OPPORTUNITIES: MAP MEMBERS AND OTHER KEY MESSENGERS

- Present an overview of MAP to key staff at your organization
- Tailor and disseminate NQF-created materials to better reach organizations you regularly connect with
- Include materials about MAP in upcoming, scheduled presentations

- Use your organization's social media resources, such as Facebook, blogs, and Twitter, to provide information about MAP, its accomplishments, finalized work products, and meetings; make reminders about public comment and participation opportunities; and request input to be utilized in feedback loops, etc.
- Disseminate MAP materials at your own or other external meetings, encouraging peers and colleagues to participate in building effective feedback loops, joining public meetings, and providing insight during commenting periods and other opportunities to provide input to ensure stronger bi-directional communication, and connect the MAP work to initiatives important to your local audiences (e.g., events, topics in the news, etc.)
- Host a meeting specifically designed around building measure use feedback loops or gathering measure use information (note this would require additional funding)

OPPORTUNITIES: NQF STAFF

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

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

NQF Staff Deliverables

Action/Deliverable	Timeframe/Deadlines
One-pager describing what MAP is and its function	October 2012
Core set of PowerPoint slides outlining the basics of MAP	October 2012
A tough-questions guide for internal use	October 2012
A frequently asked questions guide for external use	October 2012
A messaging guide	October 2012
Short versions of all MAP materials, presented in ways that comply with plain language principles	October 2012
Template newsletter articles	October 2012
Making connections document	October 2012
Communications inventory	December 2012
Infographic illustrating what MAP is and how it relates to other work being done at NQF and with other NQF-convened groups	Early 2013
Infographic illustrating how MAP fits with and relates to external work being done by QASC, AHRQ, NCQA, and others	Early 2013
Toolbox to contain all important materials—one-pagers, fact sheets, reports, PowerPoint slides, etc.	Early 2013
Educate staff about MAP and how it relates to the work of NQF	Early 2013
Review accomplishments and set goals for increased engagement in year two	End of 2013
Outreach to communications staff of MAP members	Early 2013

STRATEGIC PLANNING PROCESS

During the course of its first-year activities, MAP identified significant opportunities to enhance its partnership with the stakeholders across the quality enterprise in order to achieve the NQS aims. To lay out a multi-year strategy, MAP convened a 13-member Strategy Task Force—composed of the MAP Coordinating Committee co-chairs, the MAP workgroup chairs, the National Priorities Partnership (NPP) co-chairs, and additional MAP Coordinating Committee members to achieve a balance of stakeholder interests—to advise the MAP Coordinating Committee on a three-year strategic plan.

MAP Strategy Task Force Roster

CO-CHAIRS (VOTING)
Chip Kahn
Gerry Shea

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

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

To ensure transparency and to receive comprehensive input from a wide variety of stakeholders, MAP developed the **MAP Approach to the Strategic Plan** to receive early input before developing the MAP Strategic Plan. To develop the Approach to the Strategic Plan, the task force had one in-person meeting; the plan was reviewed and vetted by the MAP Coordinating Committee during two Coordinating Committee web meetings. Later, the Approach to the Strategic Plan was reviewed during an all MAP web meeting in order to inform the development of the Strategic Plan.

To further develop the Strategic Plan, the Strategy Task Force had one in-person meeting and one web-meeting. Additional input was sought during a combined all MAP web meeting and an NQF all member web meeting. Subsequently, the MAP Coordinating Committee reviewed and further revised the draft report during an in-person meeting. The agendas and materials for the Strategy Task Force meetings can be found on the **NQF website**.

MAP solicited and received public feedback on the Strategic Plan during a formal two-week commenting period (see Appendix C for public comments received).

The MAP Approach to the Strategic Plan was submitted to HHS on June 1, 2012; the final MAP Strategic Plan was submitted to HHS on October 1, 2012.

APPENDIX A:
MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs. 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]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures HHS will receive varied and thoughtful input on performance measure selection. In particular, the ACA-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a more global and strategic way.

MAP is designed to facilitate progress on the aims, priorities, and goals of the National Quality Strategy (NQS)—the national blueprint for providing better care, improving health for people and communities, and making care more affordable.[2] Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP's objectives are to:

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

Coordination with Other Quality Efforts

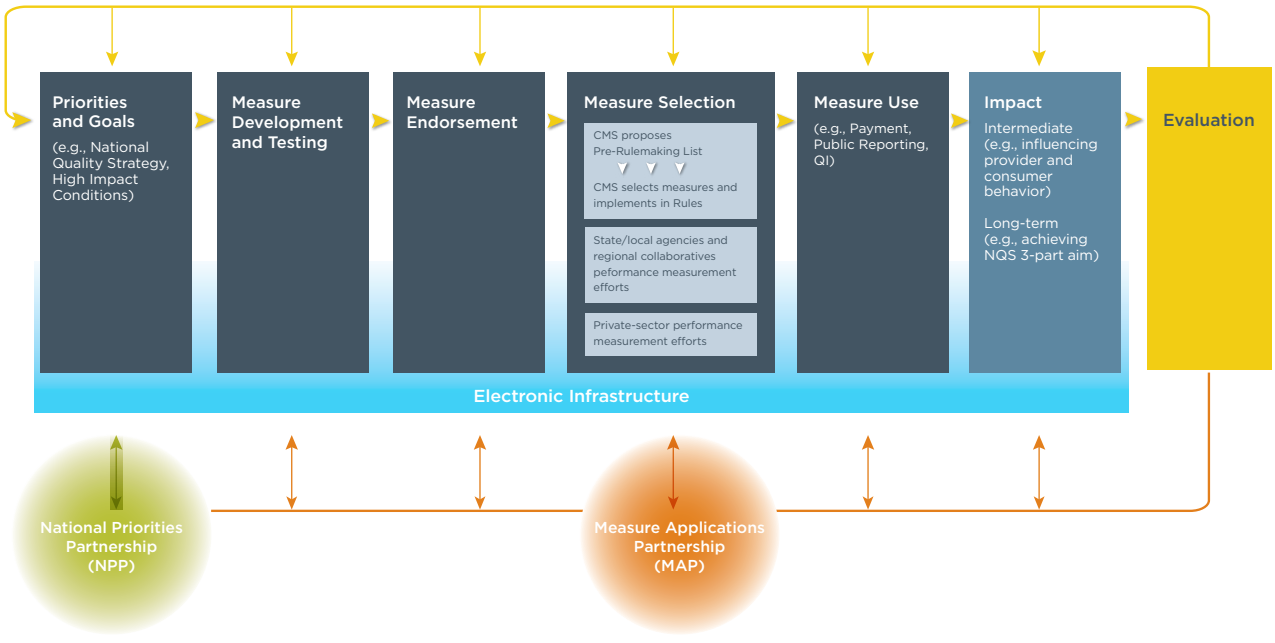
MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decision-making, aligning payment with value, rewarding providers and professionals for using health information technology (health IT) to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust Quality Enterprise (see Figure 1) that includes:

- **Setting priorities and goals.** The National Priorities Partnership (NPP) is a multi-stakeholder group convened by NQF to provide input to HHS on the NQS, by identifying priorities, goals, and global measures of progress. The priorities and goals established serve as a guiding framework for the Quality Enterprise.
- **Developing and testing measures.** Using the established NQS priorities and goals as a guide, various entities develop and test measures (e.g., AMA-convened PCPI, NCQA, The Joint Commission, medical specialty societies).
- **Endorsing measures.** NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.
- **Measure selection and measure use.** Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private sector entities. MAP's role within the Quality Enterprise is to consider and recommend measures for public reporting, performance-based payment, and other programs. Through strategic selection, MAP facilitates measure alignment of public- and private-sector uses of performance measures.
- **Impact.** Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate if measures are having their intended impact and are driving improvement, transparency, and value.
- **Evaluation.** Evaluation and feedback loops for each of the functions of the Quality Enterprise ensure that each of the various activities is driving desired improvements.

MAP seeks to engage in bi-directional exchange (i.e., feedback loops) with key stakeholders involved in each of the functions of the Quality Enterprise.

FIGURE 1. FUNCTIONS OF THE QUALITY ENTERPRISE

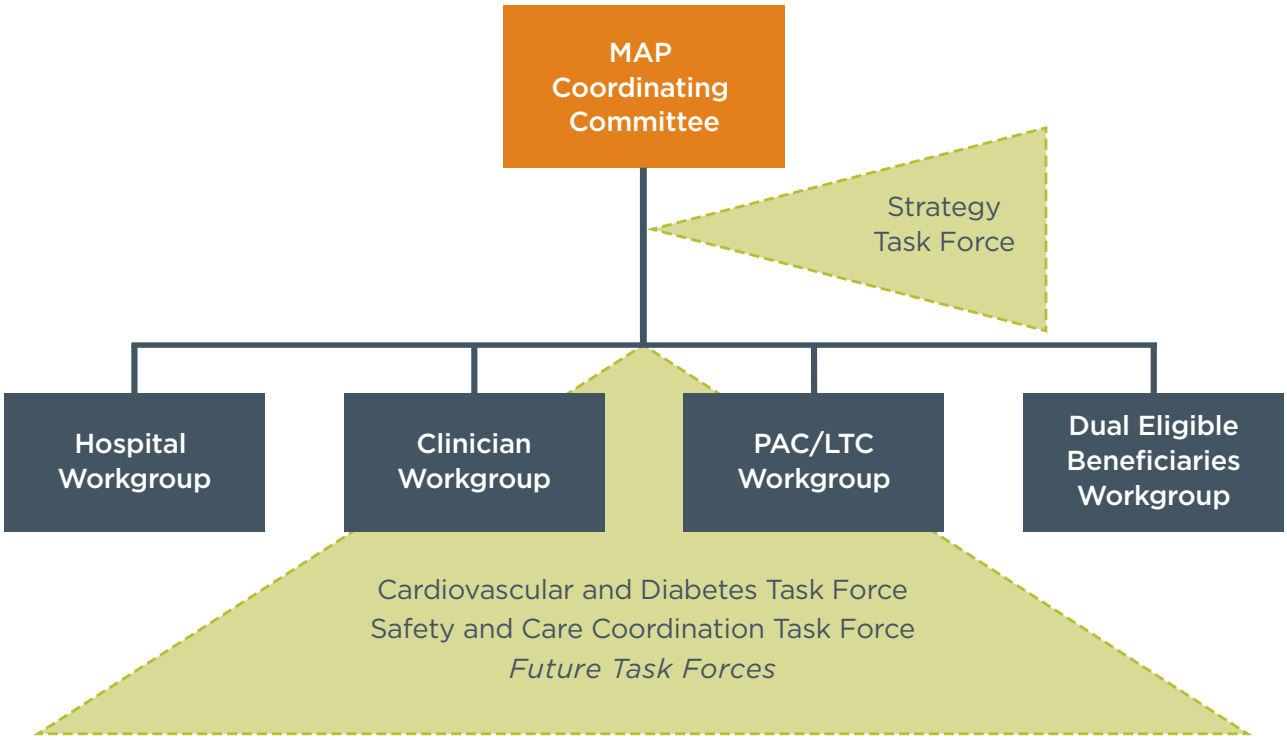


Structure

MAP operates through a two-tiered structure (see Figure 2). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations.

Time-limited task forces charged with developing "families of measures"—related measures that cross settings and populations—and a multi-year strategic plan, provide further information to the MAP Coordinating Committee and workgroups. Each multi-stakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

FIGURE 2. MAP 2012 STRUCTURE



The NQF Board of Directors 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 Board selected the Coordinating Committee and workgroups 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 also was imperative.

All MAP activities are conducted in an open and transparent manner. The appointment process includes open nominations and a public comment 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. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed® Patient-Focused Episodes of Care framework,[3] the HHS Partnership for Patients safety initiative,[4] the HHS Prevention and Health Promotion Strategy,[5] the HHS Disparities Strategy,[6] and the HHS Multiple Chronic Conditions framework.[7]

Additionally, the MAP Coordinating Committee has developed Measure Selection Criteria to help guide MAP decision-making. The MAP Measure Selection 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 the measure set addresses the NQS's priority areas and the high-impact conditions, and by whether the measure set advances the purpose of the specific program without creating undesirable consequences.

Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1. (**MAP 2012 Pre-Rulemaking Report**, submitted to HHS February 1, 2012).

Additionally, MAP engages in strategic activities throughout the spring, summer, and fall to inform MAP's pre-rulemaking input. To date MAP has:

- Engaged in **Strategic Planning** to establish MAP's goal and objectives. This process identified strategies and tactics that will enhance MAP's input.
  - **MAP Approach to the Strategic Plan**, submitted to HHS on June 1, 2012
  - **MAP Strategic Plan**, submitted to HHS on October 1, 2012
- Identified **Families of Measures**—sets of related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS priorities and high-impact conditions—to facilitate coordination of measurement efforts.
  - **MAP Families of Measures: Safety, Care Coordination, Cardiovascular Conditions, Diabetes**, submitted to HHS on October 1, 2012
- Provided a measurement strategy and best available measures for evaluating the quality of care provided to Medicare/Medicaid **Dual Eligible Beneficiaries**.
  - **Measuring Healthcare Quality for the Dual Eligible Beneficiary Population**, submitted to HHS on June 1, 2012)
- Developed **Coordination Strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives. Each coordination strategy addresses measures, gaps, and measurement issues; data

sources and health information technology implications; alignment across settings and across public- and private-sector programs; special considerations for dual-eligible beneficiaries; and path forward for improving measure application.

- **Coordination Strategy for Clinician Performance Measurement**, submitted to HHS on October 1, 2011
- **Readmissions and Healthcare-Acquired Conditions Performance Measurement Strategy Across Public and Private Payers**, submitted to HHS on October 1, 2011
- **MAP Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement**, submitted to HHS on February 1, 2012
- **Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals**, submitted to HHS on June 1, 2012
- **Performance Measurement Coordination Strategy for Hospice and Palliative Care**, submitted to HHS on June 1, 2012

Endnotes

1 U.S. Government Printing Office (GPO). Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014. Washington, DC: GPO; 2010, p.260. Available at www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed August 2011.

2 http://www.healthcare.gov/law/resources/reports/nationalqualitystrategy032011.pdf

3 NQF, Measurement Framework: Evaluating Efficiency Across Patient Patient-Focused Episodes of Care. Washington DC: NQF; 2010. Available at www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx. Last accessed March 2012.

4 Department of Health and Human Services (HHS), Partnership for Patients: Better Care, Lower Costs. Washington, DC: HHS; 2011. Available at www.healthcare.gov/center/programs/partnership. Last accessed March 2012.

5 HHS, National Prevention, Health Promotion and Public Health Council (National Prevention Council). Washington, DC: HHS; 2011. Available at www.healthcare.gov/center/councils/nphpphc/index.html. Last accessed March 2012.

6 HHS,. National Partnership for Action to End Health Disparities, Washington, DC: HHS; 2011. Available at http://minorityhealth.hhs.gov/npa/. Last accessed March 2012.

7 HHS, HHS Initiative on Multiple Chronic Conditions, Washington, DC: HHS: 2011. Available at www.hhs.gov/ash/initiatives/mcc/. Last accessed March 2012.

APPENDIX B:
MAP Measure Selection Criteria and Interpretive Guide

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

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

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

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

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

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

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

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

NQS priority is adequately addressed in the program measure set

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

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

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

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

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

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

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

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

Subcriterion 4.1 Program measure set is applicable to the program's intended care setting(s)

Subcriterion 4.2 Program measure set is applicable to the program's intended level(s) of analysis

Subcriterion 4.3 Program measure set is applicable to the program's population(s)

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

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

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

Subcriterion 5.1 Outcome measures are adequately represented in the program measure set

Subcriterion 5.2 Process measures are adequately represented in the program measure set

Subcriterion 5.3 Experience of care measures are adequately represented in the program measure set (e.g., patient, family, caregiver)

Subcriterion 5.4 Cost/resource use/appropriateness measures are adequately represented in the program measure set

Subcriterion 5.5 Structural measures and measures of access are represented in the program measure set when appropriate

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

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

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

Subcriterion 6.1 Measures within the program measure set are applicable across relevant providers

Subcriterion 6.2 Measures within the program measure set are applicable across relevant settings

Subcriterion 6.3 Program measure set adequately measures patient care across time

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

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

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

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

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

8. Program measure set promotes parsimony

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

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

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

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

TABLE 1: NATIONAL QUALITY STRATEGY PRIORITIES

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

TABLE 2: HIGH-IMPACT CONDITIONS

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

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

MAP Measure Selection Criteria Interpretive Guide

Instructions for applying the measure selection criteria:

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

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

FOR CRITERION 1—NQF ENDORSEMENT:

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

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

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

- the extent to which the measure(s) under consideration has been sufficiently tested and/or in widespread use.
- whether the scope of the project/measure set is relatively narrow.
- time-sensitive legislative/regulatory mandate for the measure(s).

Measures that are NQF endorsed are broadly available for quality improvement and public accountability programs. In some instances, there may be evidence that implementation challenges and/or unintended negative consequences of measurement to individuals or populations may outweigh benefits associated

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

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

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

FOR CRITERION 3—PROGRAM MEASURE SET ADDRESSES HIGH-IMPACT CONDITIONS

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

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

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

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

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

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

1. **Outcome measures**—Clinical outcome measures reflect the actual results of care.[3] Patient-reported measures assess outcomes and effectiveness of care as experienced by patients and their families. Patient-reported measures include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference.[4]
2. **Process measures**—Process denotes what is actually done in giving and receiving care.[5] NQF endorsement seeks to ensure that process measures have a systematic assessment of the quantity, quality, and consistency of the body of evidence that the measure focus leads to the desired health outcome.[6]
3. **Experience of care measures**—Defined as patients' perspective on their care.[7]
4. **Cost/resource use/appropriateness measures**

   a. Cost measures—Total cost of care.

   b. Resource use measures—Resource use measures are defined as broadly applicable and comparable measures of health services counts (in terms of units or dollars) that are applied to a population or event (broadly defined to include diagnoses, procedures, or encounters).[8]

   c. Appropriateness measures—Measures that examine the significant clinical, systems, and care coordination aspects involved in the efficient delivery of high-quality services and thereby effectively improve the care of patients and reduce excessive healthcare costs.[9]
5. **Structure measures**—Reflect the conditions in which providers care for patients.[10] This includes the attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure (such as medical staff organizations, methods of peer review, and methods of reimbursement).[11] In this case, structural measures should be used only when appropriate for the program attributes and the intended population.

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

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

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

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

Measures sets should be able to detect differences in quality among populations or social groupings. Measures should be stratified by demographic information (e.g., race, ethnicity, language, gender, disability, and socioeconomic status, rural vs. urban), which will provide important information to help identify and address disparities.[12]

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

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

FOR CRITERION 8—PROGRAM MEASURE SET PROMOTES PARSIMONY:

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

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

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

ENDNOTES

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

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

3 NQF, 2011, *The Right Tools for the Job*. Available at www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx. Last accessed May 2012.

4 Consumer-Purchases Disclosure Project, 2011. Ten Criteria for Meaningful and Usable Measures of Performance.

5 Donabedian, A., The quality of care, *JAMA*, 1998;260:1743-1748.

6 NQF, 2011, Consensus development process. Available at www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx. Last accessed May 2012.

7 NQF, 2011, *The Right Tools for the Job*. Available at www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx. Last accessed May 2012.

8 NQF, 2009, National Voluntary Consensus Standards for Outpatient Imaging Efficiency. NQF, Washington, DC. Available at www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70048. Last accessed May 2012.

9 NQF, 2011, *The Right Tools for the Job*. Available at www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx. Last accessed May 2012.

10 Ibid.

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

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

APPENDIX C:
Public Comments

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments		Jane Horvath	Merck recognizes and appreciates the role of NQF and MAP in advancing the National Quality Strategy (NQS) in supporting the goal of patient–centered measurement across multiple domains. With MAP's 'primary purpose to provide input on performance measures for numerous accountability applications', Merck recommends that the research and development based biopharmaceutical industry be recognized as a key stakeholder and be represented on the MAP or at least on specific workgroups. Pharmaceuticals are a common component in the delivery of quality healthcare in all care settings to improve patient health outcomes. The biopharmaceutical research and development sector brings substantial scientific expertise with rigor in data and outcomes across all patient populations. The more key stakeholders who are represented in the development process enhances MAP's value and outputs. Merck appreciates the opportunity to provide input into the MAP by this comment process. However, the timeframe for review and comments about the Strategic Plan is too compressed for a thorough review, especially since this is not subject to a federal deadline. We respectfully request additional time to supply meaningful, thoughtful comments during MAP's next open comment period.
General Comments	American Board of Medical Specialties	Tom Granatir	Measurement Applications We were pleased to hear the concept of measure "fitness" find its way into the report and strongly urge a discussion of what it means for a measure to be "fit for purpose." Despite the fact that the Clinician Workgroup showed a "strong consensus" that "measure sets need to be evaluated in the context of a specific purpose," those purposes were never discussed and the fitness of the measures has never been evaluated. There appears to have been an underlying assumption that measures should be multi-purposed, and that this is possible and desirable for all measures. We encourage the MAP to examine this assumption in a more thorough discussion of the way measures will be deployed.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	American Board of Medical Specialties	Tom Granatir	Feedback Loops The Plan calls for the development of "feedback loops" back to the MAP to help it assess the usefulness of the measures and the ability of the measurement platform to achieve its desired aims. We strongly support the notion that the MAP seek feedback about the use of measures. We are somewhat doubtful about the ability of the MAP to set up feedback data flows and expect that the sort of feedback envisioned by the Plan will have to be supplied by the organizations deploying the measures. This will occur both at the program level (i.e., between PQRS, the accreditors, or the Boards and the MAP) and at the clinician/provider level (i.e., between the program and the clinician/provider). If performance measurement has a hope of contributing to the improvement of patient care, there must be timely data feedback to clinicians and providers. Our sense is that Maintenance of Certification is the most pervasive platform that can provide timely feedback to clinicians to help them identify improvement opportunities. The Performance Improvement Modules developed to support practice assessment by ABIM and other Boards place this measurement in the context of an improvement process, and at the same time create a vehicle for capturing information from clinicians about whether the measure sets help them to improve their care. By building on the MOC infrastructure, including its measures and improvement processes, CMS would have an opportunity to achieve meaningful change in clinical practice and also to get direct feedback on the utility of measures.
General Comments	American Board of Medical Specialties	Tom Granatir	Competencies Framework for Clinician Performance Assessment Last year we suggested a discussion about the "Competencies Framework" that was adopted a dozen years ago by ABMS and the ACGME in the 1990s as thinking evolved about what excellent clinician performance actually means. These competencies are being introduced in training curricula and they form the basis of the Maintenance of Certification programs. They have also been adopted by The Joint Commission as the basis for professional performance evaluation in hospitals. The current strategy seems to take a needlessly narrow view of clinical performance: a focus on clinical and procedural measures to the exclusion of other competencies that have a significant impact on the very issues that are so important to the MAP, issues of teamwork, communication, and system-based practice. MOC is designed to assess these issues, in addition to matters of diagnostic expertise, which is completely inaccessible through current measurement approaches. We believe that MAP would do well to leverage MOC programs and their competency framework. They are the standard for assessing physician performance. MOC programs can identify performance gaps that have not yet been contemplated by the committee — gaps in diagnostic skills, for example, in addition to gaps in medical treatment, and gaps in methods of assessment for skills and attributes that are not well assessed through statistical analysis of performance measures, like communication and teamwork.'

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	American Board of Medical Specialties	Tom Granatir	Measurement Gaps CMS has acknowledged that the currently available measures inadequately represent the range of physician practices paid for by Medicare, tipping to general internal medicine and family practice and under-representing other specialties. There is clearly a gap in terms of the areas of clinical medicine captured by existing measure sets. This particular gap was acknowledged by the Clinician Workgroup. Since then, the gaps in clinical specialty measures seem to have fallen out of the plan. The ABMS Boards could be able to provide some directional guidance to the MAP on the clinical priorities within each of the specialties where measure development should be a priority. The Boards have a process by which they identify areas of knowledge and skill that are most important to the specialty — the clinical areas most important to be assessed — and would be pleased to work with the MAP and with HHS to priorities clinical measures within the disciplines. Because the MAP starts with the premise that all recommended measures must be NQF endorsed, it misses the opportunity to leverage the hundreds of measures that have been developed by the Boards to support their MOC programs. ABIM alone has over 600 measures in use in its MOC programs. We believe that the MOC pathway for measuring and improving practice, using measures that are clinically meaningful and acceptable to the clinicians using them, ought to be more fully explored. The strategy focuses on measure gaps not specific to the areas of clinical practice, notably in areas of patient preference, patient experience, functional status, care coordination, mental and behavioral health, cost, overuse, and appropriateness. We agree that there is a huge need for more work on patient-reported measures of function, mental health, quality of life, experience, and health risk; appropriateness measures; and measures specific to discrete populations. The MAP focus on these issues will send a strong signal to the measures market to focus development in these areas. Although there was some useful recent discussion of and support for the use of composite measures, particularly for use in public accountability programs, we are unclear at this point whether the MAP will support and recommend them. These might be especially useful to patients who might be better guided by summary measures that capture more globally the ability of clinicians to manage clinical problems than by discrete clinical process measures or even outcome measures that might not be proximate to individual clinician performance. ABIM has been developing composites and believes that they can help clinicians, too, to obtain useful perspective on their overall performance in an area of clinical practice. We would welcome further consideration of composite measures in future discussions.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	American Board of Medical Specialties	Tom Granatir	Data and Methods Gaps While we are certain that the MAP will have its hands full with its work on measurement gaps, we continue to think that there is an important opportunity for the MAP to start a conversation on both data gaps and methods gaps. The limitations of conventional inferential statistical approaches for the assessment of individual physician performance are well known and were clearly highlighted in last year's test of the proposed criteria for clinician measurement. There was some fruitful discussion last year about the data platform to support a more fluid system of measurement. The Clinician Workgroup turned its attention to data collection and made recommendations for more "data liquidity" that would enable the creation of multiple measures out of that same data elements. A more flexible and "liquid" data collection strategy may provide more flexibility around measurement development, and may also increase methodological opportunities. What has happened to that discussion and where does it fit into the Plan? We think a more focused discussion of methodological and data issues needs to take place. In the meetings this week there was quite a bit of talk about the need for risk stratification and risk adjustment, but we have little sense from the Plan about how such methodological issues will be addressed. We think it is time to take a hard look at our data sources and methodological resources.
General Comments	American Board of Medical Specialties	Tom Granatir	New approaches to consensus development And finally, we would encourage some reflection about whether the "single, streamlined process" for measure identification and endorsement will continue to be the best and most efficient way for MAP to approach its work. We have been tremendously impressed with the wide range of values and concerns brought to the table at the Coordinating Committee meetings. There is no doubt that broad stakeholder involvement has improved the quality of recommendations to CMS and at the same time increased the level of consensus around the table. Our fear is that a single, linear process, while useful for providing focus and direction, may inhibit innovation and slow rather than accelerate progress. Toward the end of the meeting last week, Beth McGlynn raised a question about whether, in our world of wikis and information and attention markets, we need to think about other ways of getting input and identifying consensus on measures. This would be a useful conversation to have, too. The report suggests the need for a lot of rigorous thinking ahead to makes sure that the effort invested in building our data and measurement infrastructure will yield commensurate benefits. We look forward to being a part of that ongoing dialog.
General Comments	CAPC	Diane Meier	CAPC applauds MAP's approach to quality improvement and commitment to patient-centered care. We are in strong agreement with the theme that runs throughout the strategy report: that quality care for individuals with high-impact conditions, multiple chronic conditions, and serious illness includes care coordination, patient and family engagement, recognition and treatment of pain and symptoms, and appropriate care planning.

Comment Category	Commenter Organization	Commenter Name	Comment
General Comments	Children's Hospital Association	Ellen Schwalenstocker	The Children's Hospital Association appreciates the opportunity to comment on this important work. Considering its importance and an emphasis on stakeholder engagement, we are disappointed with the very short timeframe available for commenting on the strategic plan. Although we recognize the vast amount of work involved and contractual time constraints, we hope that the development of a strategic plan will ensure more time for stakeholder comment in the future.
General Comments	National Partnership for Women & Families	Tanya Alteras	The Consumer-Purchaser Disclosure Project, while not a member of the MAP, has been closely following its efforts since the body began in 2011. We are pleased to see MAP members looking back over the inaugural year in order to create a vision for how it will move forward to reach its goals. We appreciate the opportunity to provide comments on the goals and objectives as well as the various components of the MAP Action Plan.
General Comments	PhRMA	Jennifer Van Meter	Within the Strategic Plan, MAP identifies numerous stakeholders in the healthcare sector and quality enterprise; however, the biopharmaceutical research sector is not among them. Biopharmaceutical innovators contribute to higher quality care, improved health outcomes, and the quality enterprise. We are committed to collaborating with others to build upon the quality improvement work that has taken place to date. The biopharmaceutical research sector brings substantial expertise into any discussion of quality and healthcare data because it generates a large volume of health outcomes data. Furthermore, pharmaceuticals span all patient populations, all provider groups, and all health states, making pharmaceuticals a common denominator in the delivery of quality healthcare. As such, we believe the research-and-development-based biopharmaceutical industry must be represented as a stakeholder within the MAP. PhRMA appreciates the importance of the MAP's work. We appreciate the opportunity to provide input into the process, including submitting comments about the Strategic Plan. However, the period for review and comments about the Strategic Plan is too short, especially since its development timeline is not subject to a federal deadline. We respectfully request additional time to supply meaningful, thoughtful comments during MAP's next open comment period.
Purpose/ Background/Goals and Objectives	America's Health Insurance Plans	Carmella Bocchino	We recommend that MAP use the priorities of the National Quality Strategy to develop and implement specific quality improvement efforts. Output from these quality improvement efforts can then be used to inform measure development and application strategies to increase the value of measurement.
Purpose/ Background/Goals and Objectives	CAPC	Diane Meier	The Center to Advance Palliative Care applauds MAP's person-centered approach to measure selection, with its emphasis on patient-reported outcomes, experience, and shared-decision making. However we urge the MAP to remain mindful that the sickest and most vulnerable patients may not be able to engage with surveys and reports, and that an adequate substitute will have to be made for these individuals.

Comment Category	Commenter Organization	Commenter Name	Comment
Purpose/ Background/Goals and Objectives	Children's Hospital Association	Ellen Schwalenstocker	The Children's Hospital Association appreciates the opportunity to comment on the Measure Application Partnership Strategic Plan: 2012 – 2015. Although the reason for convening of the MAP is given in the first paragraph and the role of the MAP is described in the background, those descriptions seem more limited ("give input," "help coordinate") than the objectives (e.g., "improve outcomes in high leverage areas") would suggest. The Association suggests that a strong and explicit statement on the purpose of the MAP (in addition to the purpose of the strategic plan) would strengthen the beginning sections. The challenges listed in the first section are well-stated. It might be helpful to explicitly describe how the proposed strategies are addressing the challenges.
Purpose/ Background/Goals and Objectives	National Partnership for Women & Families	Tanya Alteras	The "Goals and Objectives" section states that "the selection of performance measures [is meant] to achieve the goal of improvement, transparency and value for all." We strongly suggest adding "accountability" here. There is a difference between transparency and accountability, and unless accountability is listed here as a goal, that nuance could get lost. We see that accountability is referenced in the Strategies section, in the context of "accountability applications" but we view it as being broader than that and believe it should be made a goal.
Purpose/ Background/Goals and Objectives	Renal Physicians Association	Robert Blaser	RPA urges the MAP to recognize the large percentage of dual eligible patients with end stage renal disease (ESRD). Per 2009 USRDS data, dual eligible patients made up slightly more than 25% of the total ESRD population – 147,223 of 571,414 patients (includes transplant patients). Thus, this is an important group on which there needs to be some focus of measures.
Strategies and Feedback Loops		Jane Horvath	For the Measure Lifecycle and Feedback Loops across the Functions of the Quality Measurement Enterprise, Merck recommends alignment of measure maintenance processes to the more expanded view of harmonization of measures across multiple domains in line with current clinical guidelines and best evidence. In addition, use of electronic specifications to further align to and support Health Information Exchange, and assessment which extends beyond 'removal of low-value measures' would be a more comprehensive approach.
Strategies and Feedback Loops	American College of Cardiology	William Zoghbi, MD, FACC	The College supports plans to establish bi-directional feedback loops with stakeholders involved in quality measurement. It is critically important that all stakeholders are active participants. To ensure MAP's success, physicians and measure developers need a larger representation on the MAP Coordinating Committee, Workgroups, and Task Forces. These two stakeholder groups understand the evidence-based clinical guidelines and methodological issues associated with measure development. They can also share "end-user" experience to better inform MAP of the most useful measures to improve patient care and identify challenges such as barriers to data collection or unintended consequences. We believe physician and measure developer stakeholders have a breadth of knowledge that would enhance MAP's work and hope to see additional opportunities for these stakeholders to play a greater role in activities moving forward.

Comment Category	Commenter Organization	Commenter Name	Comment
Strategies and Feedback Loops	American Medical Association	Carl Sirio	The Strategic Plan discusses the need for multi-directional collaboration among the many stakeholders engaged in performance measurement efforts to achieve the goals of the National Quality Strategy (NQS). The AMA agrees that feedback loops are essential for creating timely and meaningful collaboration around performance measurement. To maximize efficiency of resources, we recommend that the MAP balance the need to establish an infrastructure for feedback loops with existing feedback activities already in place. These current feedback loops include among others, monthly Centers for Medicare and Medicaid Services (CMS) national provider calls, where callers provide direct feedback to the agency about what measures are not being captured correctly, to issues around claims processing with data warehouses; CMS calls with measure developers to review measure specifications and testing results; specialty society input through the AMA convened Physician Consortium for Performance Improvement (PCPI) during the measure development and testing phases; and monthly calls the hospitals convene with CMS staff involved in Hospital Compare, hospital value based purchasing, and the Hospital Inpatient Quality Reporting program. While these current feedback loops are not interconnected, it is important to recognize that they exist, and provide opportunities to foster and collect useful feedback on the development, maintenance, testing, and use of measures across a variety of CMS programs. The AMA encourages the MAP to use existing feedback loops so that additional infrastructure will only need to be created to gather information that is not currently available. It is important to note that the work of the National Quality Forum (NQF) to endorse measures for use serves as another important feedback loop. The AMA urges the MAP to define how it will monitor and track the NQF consensus development
Strategies and Feedback Loops	America's Health Insurance Plans	Carmella Bocchino	We recommend that MAP develop a feedback loop so that organizations implementing improvement activities in high-leverage areas such as diabetes, cardiovascular disease, or patient safety, can collaborate with the MAP by sharing best practices, identifying barriers and solutions, and using practical experience to determine future development, application, and refinement of measures.
Strategies and Feedback Loops	Association of American Medical Colleges	Jennifer Faerberg	The AAMC strongly supports the MAP's plan to establish feedback loops and believes the MAP workgroups must be identified as a target audience. While these workgroups are part of the MAP process they are also relevant stakeholders. The workgroups should be given the opportunity to be informed of recommendations proposed by the strategic task force/coordinating committee and learn how these recommendations will impact their work in the pre-rulemaking process. The workgroups would then be able to provide more informed feedback prior to any new process being implemented.

Comment Category	Commenter Organization	Commenter Name	Comment
Strategies and Feedback Loops	CAPC	Diane Meier	CAPC respects the importance of ensuring that recommended performance measures are scientifically acceptable, feasible, and useful for quality improvement, but we are concerned that NQF's highly restrictive validation and endorsement process is a threshold criterion for selecting measures. The current NQF endorsement process has made it very hard to develop a cohesive, comprehensive and coherent set of measures that cross settings and disease types. For instance, pain measures endorsed for cancer cannot be endorsed for use in other patient populations. Given the very limited resources for measure development and testing, the field will never have enough money to test every single measure in every single setting within every single disease category. A feasible, scientifically valid approach to surmounting this problem is needed.
Strategies and Feedback Loops	Children's Hospital Association	Ellen Schwalenstocker	The Children's Hospital Association strongly supports MAP's role in stimulating gap-filling for high-priority measurement gaps (and linking that concept with the challenge that all people's needs are not the same). The Association also applauds the inclusion of measure impact and evaluation in the feedback loops. We believe understanding the impact of the overall enterprise (in addition to the impact of individual measures) is critical to evaluation.
Strategies and Feedback Loops	National Partnership for Women & Families	Tanya Alteras	Re: Table 1: MAP Goals, Objectives Strategies and Tactics: For objective 2, we believe that there could be more specific milestones associated with private/public sector alignment. We suggest a milestone of some number of private payers/purchasers committing to implementing measures that CMS is implementing. Under objective 3, we suggest that MAP develop a tactic for achieving the specific milestone of "key purchasers and payers are aware of and engaged in MAP work. We obviously support that milestone but don't see an associated tactic for achieving it in a meaningful way. We understand that this is raised in the MAP communication plan and engagement plan sections but feel it should be brought up front to the strategies and tactics as well. Re: Table 2: MAP Feedback Loops: We suggest that some language be added to the strategic plan to clarify how the outputs will be integrated into the various MAP deliverables scheduled for the coming year (and beyond). Re: the "Why Should You Participate in MAP?" text box on page 14: in the Purchasers section, we recommend that a statement be added that MAP needs input from employers to understand the extent to which they are aligning their performance measures with those used by public programs.
Strategies and Feedback Loops	PhRMA	Jennifer Van Meter	PhRMA notes that in the discussion about the Measure Lifecycle and Feedback Loops across the Functions of the Quality Measurement Enterprise there is no recognition of or place for the maintenance process for quality measures. A maintenance process is key to ensuring that measures are rooted in current best evidence and reflect up-to-date care practices. We also note that in the discussion about measure development there is no discussion about specifying measures using electronic data elements. Ensuring that measures have electronic specifications is critical to the advancement of an electronic healthcare environment and being able to use the data found within electronic systems. We recognize that both of these are quite specific details, but we believe that they are important to include in the discussion since other fine details are also included.

Comment Category	Commenter Organization	Commenter Name	Comment
Strategies and Feedback Loops	Renal Physicians Association	Robert Blaser	RPA urges caution in the MAP's decision to limit measures to only those that are NQF-endorsed. Doing so artificially limits the measures pool, inviting measure gaps. Additionally, it conflicts with section 1848(k)(2)(C)(ii) of the Affordable Care Act that provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF). RPA supports CMS' option to select measures under this exception if there is a specified area or medical topic for which a feasible and practical measure has not been endorsed by the entity.
Strategies and Feedback Loops	Renal Physicians Association	Robert Blaser	RPA believes it is important to not duplicate efforts around filling gaps. The AMA-PCPI, medical specialty societies, and other measure developers are in the process of developing and revising measure development work plans. The big barrier is resources – without resources or prioritization from those that need measures, e.g., CMS or private plans, it is difficult to establish a measure development work plan that is relevant and responsive to health system needs.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	American College of Cardiology	William Zoghbi, MD, FACC	Addressing Measure Gaps. The College supports the coordinated effort to identify and prioritize high-leverage measure gaps, but remains concerned that MAP is operating under the assumption that there is adequate funding for measure development and that measure gaps can be filled quickly. In reality, this is not the case. Measure development is technical and resource-intensive – two important issues that are not fully captured within the draft report. These issues become exacerbated absent existing evidence-based guidelines and methodologies to support measure development. Based on our experience with updating ACC/AHA/PCPI coronary artery disease, hypertension, and heart failure measures, it can take three years or more to complete the progression from measure development through endorsement under the current NQF process. We are concerned that the draft report does not accurately capture the barriers (both financial and non-financial) and challenges to filling measure gaps and the substantial lag time from initiation of measure development to endorsement. We recommend strengthening this section to address these important issues.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	American College of Cardiology	William Zoghbi, MD, FACC	Addressing Measure Gaps. Additionally, we found that MAP has not fully differentiated whether or not a measure gap exists because measures are not available or because existing measures do not meet MAP's measure selection criteria. Instead, MAP has listed measure gaps without conducting even cursory analysis to understand why the gap exists. We encourage MAP to have more robust conversations of this issue and are happy to participate in these discussions as appropriate.

Comment Category	Commenter Organization	Commenter Name	Comment
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	American College of Cardiology	William Zoghbi, MD, FACC	Refining the MAP Measure Selection Criteria. The College supports MAP refining its measure selection criteria to address attribution, the characterization of measures best suited for different programmatic purposes, and measures retirement. We believe it is essential that the "fit for programmatic purpose" concept be integrated into MAP's measure selection criteria as soon as possible to remedy potential for unintended consequences and ensure the appropriate application of measures in specific payment and reporting programs. Likewise, it is equally important to establish an explicit mechanism to modify or remove measures from the families and core measure sets as the evidence base and practice guidelines evolve.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	American Medical Association	Carl Sirio	Approach to Stakeholder Engagement The AMA welcomes the opportunity to speak with the MAP to identify opportunities to partner on engaging the physician community around the work of identifying quality measures for use, providing feedback on their use, and filling measurement gaps. Specifically, the PCPI has a wealth of knowledge and experience working with the medical specialty societies to develop, test and maintain clinically relevant measures, and identify data sources necessary to facilitate timely and accurate quality measure capture. In addition, the PCPI has supported the concept of "groups of measures" since its inception by indentifying and developing measures sets. Most recently, the PCPI has created dashboards of measures which link desired outcomes to measures (see attached example). We would welcome the opportunity to share what we have learned with the MAP as it develops its Families of Measures.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	American Medical Association	Carl Sirio	Addressing Measure Gaps It is important not to duplicate efforts to fill measurement gaps. The PCPI, medical specialty societies, and other measure developers like The Joint Commission (TJC) and National Committee for Quality Assurance (NCQA) are continuously updating their measure development work plans. The duties and responsibilities outlined in Sec. 3014 of the Affordable Care Act (ACA) provide a clear guidepost for MAP as it continues its work on recommending quality measures for use. The AMA urges the MAP to focus its work on highlighting the areas where there are measure gaps, and then communicating these gaps clearly to measure developers, and large organizations like the AMA and others who are able to communicate these gap areas to others. One significant barrier to filling measure gaps is resources—without resources it will be very difficult to be responsive to those who are in need of these measures eg, CMS, private plans, health system, consumers. While the MAP was funded under Sec. 3014 of the ACA to carry out its consensus development work for recommending measures, and the NQF was funded under the Medicare Improvement for Patients and Providers Act of 2008 to endorse measures, the other leg of the measurement enterprise stool—measures development—was not. The AMA is working with The Stand For Quality Coalition to promote legislation that would secure funding, which if enacted, would help to support the development, specification and testing of quality measures in gap areas, as well as annual updates and maintenance of measures currently in use in various programs.

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MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	American Medical Association	Carl Sirio	Defining Measures Implementation Phasing Strategies In general, the AMA supports the proposed added categories in the Strategic Plan of "Support Direction;" "Phased Removal;" "Do Not Support;" and "Insufficient Information." These additional categorizations will allow the public to quickly identify where the measure concept stands in the MAP review process, which will improve how the MAP's measure categorizations are publicly perceived and acted upon. This is a much more constructive approach than the MAP's "do not support" category for measures that did not have specifications, but were good concepts, which sent the wrong message to payers, measure developers, and physicians. Several specialties that proposed various measure concepts to CMS expressed concern that use of the term "do not support" would signal to the public that it is not a good concept, and therefore a non starter for development work. Therefore, it is important that the MAP's recommendations are not misconstrued when electing the "do not support" category. We urge caution, however, around the use of the MAP category "phased removal." There is a growing tension between having clinically relevant measures to promote meaningful participation in Medicare quality reporting programs, like the Physician Quality Reporting System (PQRS), and the push for high bar, publicly reportable, aligned measures across settings. However, with CMS determining in its 2012 Physician Fee Schedule Final Rule that 2015 PQRS penalties will be based on 2013 performance, the stakes for meaningful participation in this program, as well as other CMS programs, have increased. If existing quality measures currently in use within federal programs like the PQRS are recommended for phased removal, what would this mean for CMS and physicians who are reporting these measures under the program? Would MAP guarantee that other comparable quality measures would be available to replace the existing relevant measure? If so, who will pay to have these measures developed, specified and tested? What if the measure recommended for "phased removal" is the only clinically relevant measure available for a particular specialty society? Will MAP acknowledge this in its "phased removal" decision? The AMA urges the MAP to further consider in its measure recommendations the issue of promoting the availability of clinically relevant measures for all physician specialties when deciding upon measure categorizations. In addition, for those measure recommendations that fall in the categories of "support direction" or "insufficient information," it would be helpful if the MAP provided input to measure developers which of these measures should be prioritized for additional development, specifications and testing. With limited resources, it is critical that measure developers receive strong green light, yellow light, or red ight signals with regard to what measures are needed in the near and distant future.

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MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	America's Health Insurance Plans	Carmella Bocchino	We recommend developing a standard framework for measurement retirement that assesses measures based on the following criteria: 1) the evidentiary basis for a measure has changed; 2) sustained high performance on a measure and achievement of a targeted benchmark; 3) low return on investment (i.e. the cost of collecting and measuring outweighs the utility of the measure); and 4) the measure has been demonstrated to have minimal impact on health outcomes and status.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	Association of American Medical Colleges	Jennifer Faerberg	As MAP seeks to develop a variety of new task forces and ad-hoc committees, the membership should be comprised of individuals not already fully engaged in the MAP process. Allowing for new membership will provide different perspectives and allow for more stakeholders to participate in the process.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	Association of American Medical Colleges	Jennifer Faerberg	The MAP structure seems to be growing substantially which may well be warranted, but we urge the MAP to be as efficient as possible in its use of resources wherever possible and not building duplicative infrastructure.

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MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	Association of American Medical Colleges	Jennifer Faerberg	The AAMC understands the concept of creating a measure family, however there is concern that a gap exists in understanding how these families will be operationalized in the various quality reporting programs. As these measure families are not designed to be the de-facto list of measures to be included in all programs, how will the MAP use these families to determine what measures are most appropriate for selection? Particularly, if these families do not offer a measure that is appropriate for a particular provider/setting/program then how should the measure workgroups determine what is is the next best option? Specific instruction should be provided to the measure workgroups on how to utilize the families in measure selection since this directly impacts their work for the pre-rulemaking process. Attribution and the unit of measurement can affect how well a measure fits within a program. In particular, there are differences between measuring health plans, facilities, individual clinicians or large clinician group practices. The report should highlight how attribution (when does a provider know which patients are being measured and what type of population is selected) and sample size can affect the reliability measures for different provider types.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	Children's Hospital Association	Ellen Schwalenstocker	With regard to identifying families of measures and core measure sets, the Children's Hospital Association appreciates the recognition that measure opportunities can vary by age. With regard to addressing measure gaps and refining the MAP measure selection criteria, we strongly support revisiting the child health high-impact conditions to ensure the prioritization reflects the current evidence base. The Children's Hospital Association has commented previously on this list, noting the importance of cross-cutting (rather than condition-specific) areas, including children with special health care needs, which may include multiple chronic conditions.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	National Partnership for Women & Families	Tanya Alteras	Stakeholder Engagement We would appreciate clarification of the introductory paragraph to this section, beginning on page 15. We find the following language confusing: "...engagement must occur 1) within MAP as a group, MAP members must bring their breadth of experiences and knowledge to allow for more informed decision-making and work to execute MAPs recommendations; 2) within MAP and with individual stakeholders, including consumers, to ensure that MAP recommendations are meaningful..." What does "within MAP as a group" mean, versus "within MAP and with individual stakeholders?" Also, why are consumers singled out here? Are consumers not already considered fully engaged participants? In the second paragraph of this section on page 15, there are several references to "end-users" of MAP recommendations; whether intentional or not, it is perceived by many that the end user of MAP recommendations is solely CMS. We strongly recommend that some language be added to strengthen the inclusion of private sector end-users, including how to bring more private sector payers and purchasers into the fold and make the recommendations of the MAP more meaningful to them.

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MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	National Partnership for Women & Families	Tanya Alteras	We see in the "Collaborators" paragraph on page 16 that MAP will engage multiple stakeholders, but this concept needs to be brought in and fleshed out much earlier. The first paragraph on page 16 states "MAP will provide members structured ways to share information on measure use and implementation experience that can inform MAP decision-making." We suggest that MAP also integrate this information into the evaluation component of the strategic plan. We see that on page 33, under Tactical Opportunities for MAP Members, there is a suggestion that members utilize their organization's social media to share information and a request that "input to be utilized in feedback loops," but we recommend that the link between the provision of this information and the MAP evaluation be made stronger.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	National Partnership for Women & Families	Tanya Alteras	Addressing Measure Gaps: All of the MAP workgroups, task forces, and the Coordinating Committee have spent considerable time discussing and prioritizing measure gaps. Consumers and purchasers are eager to understand what role MAP will play in filling those gaps, but this section of the strategic plan is not entirely clear as to who will "own" the process, once the prioritization work is complete. We certainly appreciate MAP's commitment to prioritizing the gaps, signaling where funding is most needed, and considering the measurement needs of multiple stakeholders. We ask, however, that language be added about the need for an entity or entities to liaison between MAP, funders, and developers, to move this ball down the road.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	National Partnership for Women & Families	Tanya Alteras	Analytic Support for MAP Decision-Making: At the bottom of page 24 begins a section titled "Utilize measurement information, including available information on measure use and impact" which notes that MAP will use information gleaned from the NQF endorsement process to determine usefulness of measures, along with other sources like CMS' National Impact Assessment of Medicare Quality Measures Report, AHRQ's National Healthcare Quality and Disparities Reports and Healthcare Cost and Utilization Project (HCUP) data, as well as state, community, and private sector efforts. We support the use of all of these sources but at the same time recommend that MAP also look to additional sources, such as those listed in the "Identifying Families of Measures and Core Measure Sets" section. These would include eValue8, IHA, and Bridges to Excellence, all of which can provide meaningful information on how measures are being used in the private sector and can add to the comprehensiveness of the analytic efforts.

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MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	National Partnership for Women & Families	Tanya Alteras	Refining the MAP Measure Selection Criteria: We appreciate MAP addressing the issue of the potential need for different measures to fulfill different purposes. We do have some concerns, however, about how this effort will align with NQF's consensus development process policy that all NQF-endorsed measures be suited for both public reporting and quality improvement (with public reporting being prioritized). While we understand that all the components of the strategic plan will be elaborated on with more detail in future reports, we ask for clarification of how this process will work. For example, will different measure selection criteria be created depending on whether a measure is considered suitable for public reporting vs. payment vs. clinical quality improvement? Who will make the initial determination about what application a measure can address? These are just some of the questions that arose while reading this section. Overall, we agree with the direction of this section, and suggest that the final plan reflect a connection between this activity and the "Defining Measure Implementation Phasing Strategies" activity, given that the removal of measures is part of the phasing in of new, more meaningful measures.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	National Partnership for Women & Families	Tanya Alteras	Evaluating MAP's Processes and Impact: We support the proposed plan for evaluating MAP's work, but suggest one additional element be added: When MAP collects information on the rationale for why CMS or other end-users did not take the MAPs recommendations, we recommend MAP then feed that information into the measure selection criteria. Based on the recommendations made by the MAP in February, and the response from CMS in its rulemaking for both the Inpatient and Outpatient Prospective Payment System Quality Reporting Programs, there are already examples of disconnect between the MAP recommendations and end-user actions. In addition to understanding better why that disconnect occurs, we believe that it would add tremendous value to the entire enterprise if that information had the potential to inform the measure selection criteria.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	National Partnership for Women & Families	Tanya Alteras	MAP Communications Plan: We are very impressed by the list of communication materials provided on page 32 of the strategic plan and believe that as a portfolio, they will achieve the goal of engaging and educating stakeholders on the purpose and objectives of the MAP. We suggest that – time permitting – MAP offer draft materials to consumer and purchaser stakeholders to review in terms of "digestibility." Consumers and purchasers are eager to continue their involvement in and tracking of MAP efforts, and could provide valuable feedback in terms of how understandable and meaningful are the materials being developed.

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MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	Renal Physicians Association	Robert Blaser	RPA believes it is important to not duplicate efforts around filling gaps. The AMA-PCPI, medical specialty societies, and other measure developers are in the process of developing and revising measure development work plans. The big barrier is resources – without resources or prioritization from those that need measures, e.g., CMS or private plans, it is difficult to establish a measure development work plan that is relevant and responsive to health system needs. RPA urges MAP focus on highlighting the areas where there are measure gaps, and then communicating these gaps clearly to measure developers.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	Renal Physicians Association	Robert Blaser	RPA believes it would be helpful if MAP would focus more on "impact of burden" with regard to measure selection and use. It would also be helpful if MAP could help communicate what measure concepts should be prioritized for specification development. With limited resources, it is critical that measure developers received strong green lights, yellow lights, or red lights with regard to what their measure development focus should be for current or future years. RPA urges MAP focus on highlighting the areas where there are measure gaps, and then communicating these gaps clearly to measure developers.

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MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	Service Employees International Union	Dionne Jimenez	MAP Action Plan: Identifying Families of Measures and Core Measure Sets 1. The MAP should include direct care workforce related measures where they exist or, at a minimum, address the lack of measures as a priority for measure gaps for areas where they do not exist. For example, in terms of the safety subtopic of pressure ulcers, appropriate staffing levels, especially in nursing homes, and staff training are vitally important for reducing the prevalence and severity of this type of injury from immobility. In addition, HCBS workers, both clinical and non-clinical, have intense day-to-day contact with patients and are able to both monitor and implement specific aspects of the post-discharge care plan. Appropriate workforce training and development are essential in ensuring that patients are able to appropriately benefit from care coordination efforts. 2. The MAP should recognize the importance of non-clinical care providers and caregivers beyond family members in improving quality and outcomes, and should include measures applicable to HCBS, especially for home care/personal care assistance, wherever appropriate or at a minimum address the lack of measures as a priority for measure gaps. While some measures seemingly address, HCBS, for example home health providers, measures and text do not reflect the distinct roles played by home care workers who do not provide clinical treatments but assist individuals with activities of daily living that are essential to patient treatment, recovery, and maintenance as well as, in some cases, adherence to care plans. For measures applicable to HCBS workers, it should be clear that ultimate reporting and oversight should fall to clinicians and clinical providers since they have the authority and resources to ensure measure compliance by HCBS workers.
MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	Service Employees International Union	Dionne Jimenez	MAP Action Plan: Addressing Measure Gaps 1. Since only currently NQF endorsed measures or developed and tested measures are under consideration for MAP recommendation for the Families of Measures, one concern is that many of the measures are hospital-centric since other care settings do not have existing endorsed measures for some of Families of Measures subtopic areas. The MAP should focus more on how some of the endorsed/tested measures can be slightly modified so they can be applicable for non-hospital settings, but not necessarily go through a rigorous and long measure development and testing process. We understand these issues will be part of the Gap-Filling Pathways, however, we believe that the MAP must begin to discuss these issues in more depth and be more specific on timelines and recommendations on which measures should be expanded or modified.

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MAP Action Plan (which includes Stakeholder Engagement, Families of Measures and Core Sets, Addressing Measure Gaps, Defining Measure Implementation Phasing Strategies, Analytic Support, MAP Measure Selection Criteria, Evaluation)	Venn Strategies	Stephanie Silverman	The Roundtable on Critical Care Policy supports the MAP Strategic Plan for 2012-2015. The Roundtable applauds MAP's recent focus on care planning—care coordination at the end of a patient's life—as the ICU is a primary delivery center for palliative and end-of-life care. We are encouraged by MAP's 2013 action plan to identify families of measures for patient and family engagement. At the Roundtable's July National Summit, Delegates worked to identify current challenges to providing advanced care and opportunities for improvement through policy change. The session yielded a robust discussion on barriers to patient and family engagement, including poor communication between family members and ICU staff, and the use of quality measures to promote and incentivize best practice models that encourage conversations and engagement between patients and physicians. Equally important is engagement with family and caregivers: a frequent scenario in the ICU is the non-communicative patient whose family members are called upon to serve as a proxy and make difficult treatment decisions. The Roundtable believes it is an important that attention be given to determining the most effective ways to support and engage ICU patients and their caregivers so that they can be active participants in all stages of critical illness.

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