Partnership for Quality Measurement
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National Consensus Development and Strategic Planning for Health Care Quality Measurement

2024 Measure Strategy Summit April 11 Meeting Summary

Department of Health and Human Services
Centers for Medicare & Medicaid Services
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2024 Measure Strategy Summit

Overview

Battelle convened the 2024 Partnership for Quality Measurement (PQM) Measure Strategy Summit meeting in Baltimore, MD, on April 11, 2024, to facilitate strategic discussions among the Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR) committee members (Figure 1). The meeting focused on a debrief of the previous year's measure review cycle and solicited feedback on proposed process improvements to offer strategic guidance to Battelle and the Centers for Medicare & Medicaid Services (CMS). As a result of the meeting, Battelle and CMS received guidance from participants on (1) proposed process improvements for the upcoming PRMR and MSR cycles, (2) CMS measures under development (MUD), (3) the consensus-based entity (CBE) strategic plan, and (4) criteria to apply to Cascade of Meaningful Measures (Cascade) priority area(s) to select measures for the upcoming MSR cycle.

Figure 1. Measure Set Review Meeting Attendance

Figure 2. PRMR Committee Composition

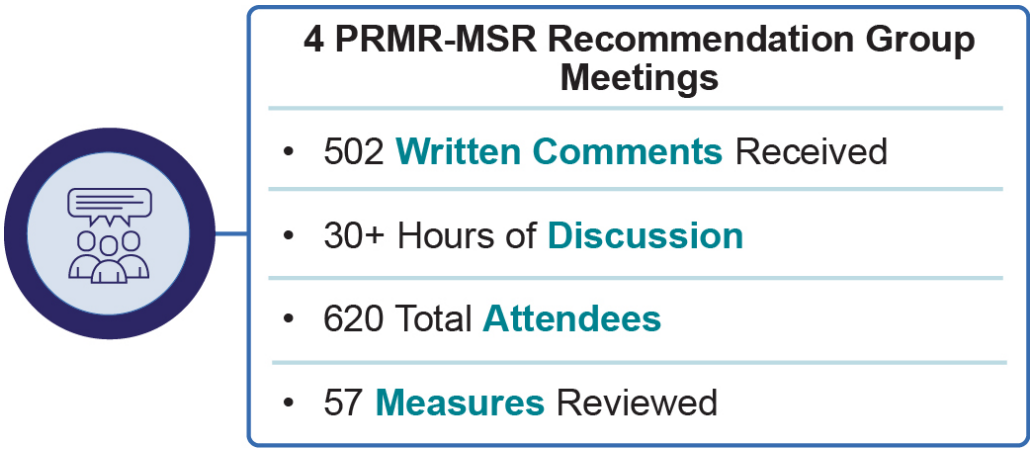

Figure 3. Engagement from PRMR-MSR Recommendation Group Meetings

The 2024 PQM Measure Strategy Summit provided an opportunity for PRMR committee (Figure 2) interaction with Battelle and CMS on strategic areas of mutual interest with the shared goal of leveraging quality measurement to advance health care and patient outcomes. Participants' enthusiasm and interest in strategic advancement of health care through quality measurement was an overarching theme for the day. Individual sessions addressed measures at various stages of development and use—from conceptualization to removal from federal quality programs—and committee members, through comments and interactions (Figure 3), demonstrated a fundamental shared support for quality measurement as a strategy for health care improvement. A summary of each presentation and breakout session follows.

Welcome and Introduction

Nicole Brennan, DrPH, MPH; Executive Director, PQM; Battelle Director, Healthcare Quality Improvement and Public Health, welcomed everyone to the meeting. Following a brief

introduction of the Battelle team and CMS representatives, Dr. Brennan emphasized the objective of this meeting. Dr. Brennan reviewed the agenda for the meeting and outlined what participants could expect during the breakout sessions. Committee members offered feedback via Mentimeter.com on the success of the PRMR/MSR process, noting transparency in all processes, productive and engaging discussions, collaboration and the inclusion of diverse perspectives. Appendix A details the complete results of the feedback collected via Mentimeter.com.

CMS Opening Welcome Remarks

Following Dr. Brennan, Michelle Schreiber, MD, Deputy Director of the Centers for Clinical Standards & Quality (CCSQ) and Director of the Quality Measurement and Value-Based Incentives Group for CMS, delivered opening remarks. Dr. Schreiber provided an overview of the CMS National Quality Strategy, highlighting its significance in an effort to improve health care quality through eight goals categorized into four priorities: equity and engagement, outcomes and alignment, safety and resiliency, and interoperability and scientific advancement. Dr. Schreiber emphasized continuous improvement and interested party engagement as part of the ongoing development of the strategy.

Consensus-Based Entity (CBE) Quality Strategy

Jeff Geppert, JD, MEd, Measurement Science Team Lead, PQM; Scientific Methods Lead, Battelle, shared the CBE Quality Strategy vision, which is to realize health care system change through the integration of quality measurement and quality improvement processes, and alignment with the principles of evidence-based policies and programs and meaningful community engagement. The strategy to achieve this vision has three components: diagnosis of a critical obstacle, a guiding policy for overcoming that obstacle, and a set of coherent actions for implementing the guiding policy. Mr. Geppert identified the perceived burden of quality measurement as the critical obstacle to leveraging quality measurement to realize health system transformation. To address this obstacle and increase the benefit of quality measurement through the CBE processes, Battelle employs a framework that leverages risk and impact dimensions to appropriately focus quality measurement where there is the most benefit for health care system change, where the risk of poor quality is high and where the impact of measurement is high.

Implementation of the strategy through coherent actions (e.g., being explicit about associations between quality measure mechanisms and outcomes, enhancing the maturity of evidence supporting quality measures, and incorporating equity and justice in quality measurement) will move a high uncertainty environment, characterized by uncertainties in improvement and impact, to a low uncertainty environment where interventions and their outcomes are understood. The guiding policies for this strategic vision include generating value for all interested parties, generating trustworthy clinical quality measures, generating consensus, and transitioning toward collaborative and community-centered problem-solving.

The CBE Quality Strategy includes the organization of the CMS measure portfolio into cycles of review using the Cascade of Meaningful Measures framework as an organizing principle for

MSR. Mr. Geppert noted that measures in the Affordability and Efficiency priority of the Cascade (also referred to as Cycle C measures) would be discussed in subsequent sessions of the meeting to identify approximately 35 measures for MSR, based on factors such as whether the mechanism (e.g., cost containment, resource utilization) underlying the measure focus is systematic and persistent in the setting of use and the degree of certainty of causal association between the mechanism(s) and measure focus.

The Cascade of Meaningful Measures: A Tool for Understanding the CMS Measure Portfolio

Following Mr. Geppert's presentation, Kimberly Rawlings, MPP, CMS National Quality Strategy Lead, provided an overview of the Cascade of Meaningful Measures (Cascade), a tool for measure prioritization that supports CMS's National Quality Strategy. The Cascade supports CMS's efforts to align or reduce measures where there are too many, identify gaps where new measures may need to be developed, and to help programs move toward measurement of Cascade of Meaningful Measures goals and objectives (e.g., through the use of composites).

Meridith Eastman, PhD, MSPH, PRMR and MSR Task Lead, provided background information on the Cascade of Meaningful Measures. The Cascade organizes measures within the CMS portfolio by health care priority of the Meaningful Measures 2.0 initiative, identifying multiple goals for each priority, and measure objectives to support each goal. Dr. Eastman indicated that to support CMS's development of the Cascade, Battelle—under the Measures Management System contract—conducted a review of peer-reviewed and gray literature to identify appropriate goals and objectives for each health care priority. Dr. Eastman provided a walkthrough of the eight health care priorities: person-centered care, safety, chronic conditions, seamless care coordination, equity, affordability and efficiency, wellness and prevention, and behavioral health.

During the review of the person-centered care priority, a committee member inquired about the omission of caregiver wellbeing in the optimal experience and engagement goals. Dr. Eastman clarified that optimal patient/caregiver experience and patient/caregiver experience will be included in an upcoming revision of the person-centered care priority. Another committee member questioned the appropriateness of the behavioral health priority being a standalone priority versus interwoven throughout the framework. CMS acknowledged that overlap exists across these priorities, goals, and objectives, and they often receive similar feedback about equity being incorporated into all priorities. CMS also highlighted an upcoming CMS Innovation Center' model that specifically looks at caregiver wellbeing.

Dr. Eastman said that the MSR process leverages the Cascade of Meaningful Measures to further the work of the CBE Quality Strategy by organizing the CMS measure portfolio into "cycles" for measure review to accomplish review of the entire portfolio in a 3-year period. For the upcoming 2024 MSR cycle, the Recommendation Group will focus on the Affordability and Efficiency health care priority within the Cascade.

MSR Breakout Sessions

Following the review of the Cascade of Meaningful Measures, committee members went into breakout groups based on committee assignment. During the breakout sessions, each committee discussed how their work can support the CBE strategy and criteria that can identify the 35 measures within the Affordability and Efficiency priority to review in the upcoming MSR cycle.

Clinician Committee

The Clinician Committee opened its breakout session by discussing whether the CBE Quality Strategy resonated with its members. A member noted that the pendulum seems to be swinging toward removing measures rather than adding them, which will be beneficial for reducing burden, as Mr. Geppert identified as the critical obstacle, in his presentation. Another member noted that the committee members are already on board with the strategy, in that they support the principle of maximizing the benefits of quality measurement. The group indicated interest in staying apprised of CBE Quality Strategy developments via meetings, such as the present one, and through asynchronous mechanisms.

The committee reviewed cards and an Excel workbook that divided the Affordability and Efficiency measures of the Cascade into three groups based on PQM's initial application of several criteria including imbalanced benefit to burden ratio, appropriateness of quality measurement as an improvement strategy, and maturity of evidence. The three groups were: measures that should be considered for removal based on application of the aforementioned criteria, measures that should be retained, and measures that PQM was unsure about whether they should be removed or retained.

The committee discussed a wide range of potential criteria that could be used to identify measures for MSR. They said criteria should reflect patient benefit and limit burden on both the patient and those that implement the measure. Criteria should reflect potential for a measure to be calculated automatically using artificial intelligence (AI) or natural language processing and whether the measure is a digital quality measure (dQM). The group had differing opinions on whether claims-based measures should be considered for dQMs. A committee member argued that administrative claims are for reimbursement, not measurement, and lack the granularity and timeliness needed by providers to improve quality. However, another member disagreed and said that some claims-based measures can be actionable and suggested that claims-based measures should be evaluated individually rather than treated with a blanket exclusionary criterion. The committee noted that many hospitals are hesitant to move toward reporting more electronic clinical quality measures (eCQMs), especially those not required by CMS, because data reported once a year is burdensome and not timely for quality improvement. The committee also suggested looking at whether a measure is immediately actionable, suitable for value-based purchasing, whether the measure's intent drives consistent behavior, and if the measure is impactful. Another committee member expressed the criteria for identifying measures for removal should be tailored to the program the measure is being implemented in, because each program has different goals. Committee members also discussed alignment of the measure with the latest evidence, between reporting mechanisms at various levels, and that

it is not duplicative of another measure in the program. Lastly, they suggested a criterion to test in diverse environments, including rural and small practices.

Some committee members found it challenging to come up with a list of criteria and proposed a walkthrough of example measures to understand how Battelle placed certain measures in each group. A member suggested that a column should be added to the shared spreadsheet explaining why each measure was assigned to each group. A patient partner noted that having background information on the measures is very important, as there is a learning curve; they would appreciate more lead time to absorb information as well as more plain-language materials.

Hospital Committee

The Hospital Committee's discussion primarily focused on two domains: uncertainty and impact. Regarding uncertainty, the committee assessed the effectiveness of methods to improve measures based on available evidence. The impact domain, meanwhile, focused on evaluating the scope and magnitude of the measure's influence. The conversation delved into how to evaluate impact effectively, especially when a measure may only affect a small population, and the committee concluded that even measures with limited population impact could be valuable if they lead to systemic improvements. The committee viewed the Cascade as a valuable tool for evaluating and understanding the progression and impact of measures.

However, committee members shared an overarching sentiment about the current approach being measure specific rather than a holistic and integrated one. Committee members stressed the importance of identifying high-leverage actions and assets that can effectively bring about meaningful improvements across the health care system. The committee discussed eCQMs, particularly the resource requirements and cost implications, highlighting the need for a structured analysis of implementation requirements, including technological and organizational needs. Lastly, members highlighted a gap in aligning measure strategies with community-specific needs within the health care system.

Post-Acute Care/Long-Term Care (PAC/LTC) Committee

The PAC/LTC Committee deliberated on how their work could support the CBE strategy. They recognized the integration of home- and community-based services as an opportunity to identify and address existing gaps and to explore current measures and the challenges providers face in navigating the system. A patient partner emphasized the importance of patient and caregiver perspectives in progressing these measures, particularly in the context of cost-related overtreatment or undertreatment within the long-term care community. A provider organization highlighted the need for alignment between quality programs and real-time clinical quality measures, stressing data collection being meaningful and directly related to program outcomes.

The committee noted the current health care system's numerous silos, indicating a need for better integration and coordination. They highlighted the importance of quality measurement in medical devices and exploration of patient rights with AI. They called for quality measures that not only consider patient involvement but also have practical applications in the daily workflow of clinicians for immediate quality improvement. A patient urged the committee to consider that

the systems we seek to measure do not exist equitably across society, emphasizing the importance of considering access to providers when developing metrics.

Next, the group considered improvements to communication for the upcoming year. Attendees encouraged exploration of ways to distinguish between action item emails and informational emails, and how to increase peer-to-peer discussion opportunities. Several committee members mentioned difficulties in locating information and the need for an easy-to-navigate website.

Lastly, the committee considered what criteria they feel are appropriate for determining which measures are part of the upcoming MSR cycle. Their discussion centered around the need for adaptability, equity, and utility in measures. There was a desire to see criteria related to equity, and the use of the CMS eight-factor removal criteria[1] was encouraged. Other potential criteria included the issue of duplicative strategies, the burden of measures, their maturity, and whether they are actionable.

Measures Under Development (MUD) Presentation and Discussion

Dr. Schreiber reviewed the list of measures CMS is currently funding the development of (known as MUD measures), discussed the priority measure concepts for development, and solicited committee feedback. The 2024 PQM Measure Strategy Summit was the very first time CMS discussed the MUD list with the committees. Dr. Schreiber indicated that sharing this information is part of CMS's continuing effort to promote transparency and obtain feedback on measures earlier on in their development and to support efficiency in the measure development and selection process.

Dr. Schreiber noted that the MUD list contains a mix of new measures and measures that are currently in use but undergoing a substantive change that requires them to go through the Measures Under Consideration (MUC) process again. She said that the committee will see an evolution of measures specifically around social drivers of health and patient safety. For example, initially CMS developed measures on screening for social drivers and the next step are measures that address the identified social needs.

Over time, CMS has introduced several eCQMs to address some of the common forms of patient harm. CMS believes that it would eventually be helpful to create a composite measure of patient harm. The proposed Inpatient Prospective Payment System (IPPS) rule supports this goal through its mandate to include more eCQMs into the program.

CMS is working on a couple of MUDs in collaboration with other federal agencies. Examples include a sepsis outcome measure with the Centers for Disease Control and Prevention (CDC) and a nursing home Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey with the Agency for Healthcare Research and Quality (AHRQ).

Dr. Schreiber then discussed high-priority measure concepts for development:

- A smoking cessation measure for hospital inpatient and outpatient settings

[1] For more information on the factors CMS uses to base decisions for measure removal, we refer readers to the Code of Federal Regulations, §412.560(b)(3). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-O/section-412.560.

- A safety measure of peritonitis in dialysis facilities
- A diabetes composite measure that includes vascular disease and amputation in the Merit-based Incentive Payment System (MIPS)
- A Hepatitis B vaccination measure, which is especially important in the dialysis facilities
- A measure of readmission and excess days in acute care for maternal health

Dr. Schreiber concluded her presentation with an update on the work with the CMS Innovation Center around Patient-Reported Outcome Measures (PROMs), noting that CMS is committed to PROMs and would like to have a standardized process for development. CMS will release a request for information (RFI) on PROMs in the future.

During the question-and-answer portion of the presentation, committee members expressed great appreciation for this information and insight into CMS's priorities for measure development. Several members encouraged CMS to provide this information to the public and solicit feedback on MUDs and priorities either through the annual pre-rulemaking process or an RFI.

A member noted that the MUD list contains two types of measures: those that capture the day-to-day provision of care and those that address national priorities, and inquired about how CMS identifies measures to develop. Dr. Schreiber replied that CMS has national priorities to which it must be responsive and that measures concepts are brought forth from many other interested parties.

Several members noted that smaller facilities have difficulty reporting measures. Dr. Schreiber and a representative from Health Resources and Services Administration (HRSA) indicated that this is an advantage of structural measures. Smaller facilities can report them, and the measures identify best practices that smaller facilities can use.

One committee member mentioned the value of claims-based measures, particularly over the next 3 to 5 years, given the shift in the Medicare population from Medicare fee-for-service to Medicare Advantage (MA). The member asked how CMS can ensure the majority of enrollees, including those in MA, are included in the measures. Dr. Schreiber replied that CMS is adding MA data into its measures and is working closely with the MA team to get access to their data.

Another member discussed the concept of "trustworthiness" in a measure. They noted that several measures on the MUD list assess complex and complicated clinician scenarios. The field may want to move them forward before they are fully tested in the way we think of measure testing today. Members of the PRMR committees could help define measure trustworthiness.

Overall, committee members expressed enthusiasm for increased transparency around priorities and MUDs and interest in providing feedback and input to CMS on these topics moving forward.

Breakout Session: PRMR-MSR Process Enhancements

Committee members joined breakout groups to discuss a selection of topics focused on the proposed PRMR/MSR process enhancements for the 2024 cycle, such as defining conditions for measures that are recommended with conditions, modifications to pre-meeting activities

such as Preliminary Assessments (PA) and committee feedback (also known as Round 1 Evaluations), and potential changes to the committee structure and activities.

Amplifying the Patient Voice

Battelle commenced the session by expressing gratitude to the patient/caregivers for their invaluable insights into the patient experience. Committee members with experience as patients/recipients of care, caregivers, and patient advocates discussed feedback for Battelle to consider. This feedback included support for the content and scope of the preliminary assessments and a request for a concise, plain language, user-friendly resource with key information readily accessible for quick reference during discussions, along with the inclusion of public comments. Committee members advocated for additional preparatory meetings between the larger group meetings to ensure clarity and comprehension of materials. Committee members made a few comments regarding the stringent timeline, with one member suggesting that multiple-choice questions are preferrable to fill-in-the-blank formats for ease of response. A member added that asking for plain/concise language usually leads to less information. One individual suggested conducting a detailed walkthrough meeting of measures, even if it is time consuming.

During the review of planned enhancements, committee members noted they could not save their progress on the committee feedback forms, and Battelle shared a solution with that feature is being investigated. There was a request for access to the Preliminary Assessments in an easy-to-find centralized location. Battelle noted that although additional time has been requested for form completion, we are unable to avoid winter holidays due to statutory requirements. Committee members indicated an interest in building relationships so they could feel comfortable reaching out to other members individually. Battelle shared plans to convene virtual patient/caregiver-specific education and preparatory meetings to bring them together, offer technical assistance, and foster peer support and engagement. To make these meetings more effective, committee members suggested a roster of the patient committee members that includes contact information and specialties.

Committee members expressed an interest in connecting with other patient partners to share data sources. A committee member noted a big learning curve with interpreting the PA and that they would like a reduction in the number of measures to ease some of the burden along with a preference for simplified language. Committee members acknowledged the utility of a measure-at-a-glance document for each measure that PQM prepared for feedback during the breakout. Committee members expressed interest in being able to access the following information as part of their pre-meeting activity: what the current and prior CMS uses of the measures are, any similar measures, and any measures with statutory requirements. If there are similar measures, they would like to review those specifications, given the cost of maintaining a measure. Additionally, a committee member suggested robust discussions around risk adjustment to help prepare the patient representatives.

Ensuring Equity and Rural Health Considerations

The group began the session by discussing the question: “What successes have you experienced in integrating rural health and equity perspectives in measure evaluation and review?” Committee members with expertise in advancing rural health and health equity reflected and shared with someone next to them and then shared with the larger group. The ensuing discussion included themes such as meeting people where they are and ensuring grassroots engagement to discern rural health care needs. A committee member raised a point around identifying assumptions about patient capabilities and removing barriers to access and literacy. An important concern for the group included aligning data collection methodologies with the population being served to ensure representation and diversity. The committee discussed the logistical challenges posed by patients travelling to providers as well as ensuring that when providers see patients they ask where they are traveling from. The discussion then delved into comments regarding the framing of what equity is and why it matters.

The session then continued with another question: “What has been challenging or what barriers have you encountered in integrating rural health and equity perspectives in measure evaluation and review?” The discussion included comments about the important role of payment models in supporting equity through integration and delivery of health care services. Other comments included the challenges of collecting complete and patient-centered data that enables evaluation of health care equity.

PRMR and MSR Enhancements Breakout 1

Committee members in both enhancement-breakout sessions had varying expertise ranging from primary care providers and specialists to individuals with experience related to post-acute/long-term care facilities. This breakout session discussed “recommendation with conditions” voting. Battelle presented a slide with four quadrants to delineate what constitutes a condition and what does not. The list of conditions included matters that CMS could address in the current rulemaking cycle, matters that CMS could address in the longer term, or matters that were not conditions. In previous PRMR meetings, committee members found the definition of conditions ambiguous, leading to concerns about how these conditions were being captured during voting. In response, Battelle introduced a slide during the PRMR meetings with instructions that those who voted “recommend with conditions” needed to state those conditions verbally or via chat.

A committee member suggested that implementing a drop-down list of conditions might facilitate thoughtful consideration among the committee. One of the most frequently named conditions was that a measure gets endorsed via the endorsement and maintenance process. PQM noted timing constraints may mean that a measure is not always endorsed when it gets to the PRMR committee. CMS wants to remain flexible so innovative measures can enter the field.

CMS rules are upfront and transparent about how many members voted for what and conditions are listed. If CMS implements a measure the PRMR committee did not recommend, an explanation is provided. In some cases, CMS may put a B- measure forward knowing that it needs some more time and tweaks to become an A+ measure. If a measure is truly low quality,

it will not proceed, but measures cannot be paused and reworked ad nauseum: this would require additional contracts and would delay the quality process for 2-3 years.

Validity and reliability scores also came up often. Committee members noted that some of the reliability and validity questions and discussions during PRMR meetings may veer into the purview of endorsement and maintenance activities, whereas PRMR is for public reporting and use in programs. Committee members expressed interest in viewing the data that E&M committee members use to make endorsement decisions.

One committee member summed up their thoughts as such: ultimately there are only two buckets—recommend or do not recommend. This committee member expressed that recommend with conditions makes members feel better, but there is no accountability, and it lowers the bar of a recommendation vote. CMS reminded the group that the discussion around the measure is just as important as the vote, noting the developer is present during the meeting but is not required to take any of the committee's recommendations.

Without a "recommend with condition" option, some committee members might vote "do not recommend." If recommend and recommend with condition votes equal 75% or greater, the measure is recommended. As such, it's important to be clear and specific about conditions.

Lastly, a committee member asked whether there was historical data detailing what people in prior PRMR processes stated as conditions. Such data could offer insights to streamline the process. Alternatively, developers could state their own conditions for how a measure could be improved. Another committee member disagreed with this approach, recalling that in previous iterations of the PRMR process, developers provided a counterpoint to every condition the committee raised, shifting the conversation away from a holistic evaluation of the measure.

PRMR and MSR Enhancements Breakout 2

During this breakout session, committee members commented on proposed enhancements to the PRMR/MSR process, which involved convening the Advisory Group and Recommendation Group co-chairs in a standalone meeting prior to measure review meetings. Questions emerged concerning the timing of this meeting and the potential burden it might impose on committee members. While the availability of the meeting to the public has yet to be determined, committee members agreed on the critical importance of transparency, with suggestions to gather feedback on the efficacy of this separate meeting. To streamline this process, committee members suggested PQM host a dedicated website for committee members to pose questions while they review measures prior to the recommendation meeting.

The breakout group expressed notable concerns about committee members recommending measures without a solid understanding, highlighting existing gaps in statistical analyses knowledge. Suggestions included simplified language and better introductions to statistical methodologies. While some committee members are familiar with certain methodologies, the complexity of some measures necessitates the involvement of subject matter experts to level the playing field. However, some members expressed that measures are sometimes grouped in ways that limit the ability to effectively leverage subject matter experts. The role of the

endorsement and maintenance committee was also emphasized, underscoring the importance of considering measure endorsement status in committee discussions and evaluation.

Summary of Next Steps and Closing Remarks

The 2024 PQM Measure Strategy Summit served as a pivotal platform to underscore the significance of quality measurement and its impact on health care systems. The feedback garnered from the committee will play a crucial role in refining the processes for both PRMR and MSR activities. In this forum, and for the first time, CMS facilitated a conversation to solicit committee feedback on MUDs, demonstrating an upstream approach that allows for additional community input and empowers developers to craft more impactful and meaningful measures. Discussions around the CMS National Quality Strategy, the CBE Quality Strategy, and how PRMR and MSR activities support these initiatives underscored the interconnectedness and collaborative nature of PQM's commitment to advance health care through quality measurement.

In closing remarks, Dr. Eastman thanked meeting attendees, noting that the 2024 PQM Measure Strategy Summit provided the forum for critical input that will be used to update the Guidebook of Policies and Procedures for PRMR and MSR, which will be available for public comment in May, and to identify measures for the Fall 2024 MSR cycle. Dr. Eastman encouraged meeting attendees to continue to engage with PQM, their committees, and strategic endeavors that advance health care through quality measurement.

Appendix A

Results displayed in the table below are reflections from PRMR members on what they appreciated about the 2023 cycle. The text included is an unaltered direct export of responses from mentimeter.com.

Add your reflections! What do you see as the greatest success from the 2023 PRMR and MSR cycle?

Transparency in all processes	Committee discussions	The materials were well organized and shared with PRMR members well in advance.	Bringing together a wide range of stakeholders.
Spectrum of measures	Collaboration with measure developers, clinical practitioners, and patients	Timely and relevant communication	An enormous number of measures were reviewed, efficient process
During our Fall in-person meeting, we "pivoted" during the afternoon session to re-explain key concepts, logistics, and timelines. That was REALLY helpful to first timers who were a little lost.	Asking for feedback about the process	Easy to understand process	Excellent preparation.
that we got through it all	multiple perspectives and collaboration	Discussions during the voting sessions.	Well organized good patient and clinician input

meeting in the fall was helpful to prepare us for review	Efficient timeline	Very organized process	Great engagement and dialog!
Great discussions.	Networking with experts	Easy to understand collaboration preparation of pre-discussion materials	The amount of people who were involved and gave their time
Changing to a new Consensus Based Entity with a new measure process.	Very well organized and led to meaningful results.	Large number of measures reviewed in a short period of time	Collaboration
Listening sessions were really helpful to hear from stakeholders	Prep material was extremely informative	Asked for feedback	Excellent time management for Recommendation meetings assured plenty of time for all voices to be heard.
Reaching out to patient advocates and to give them recognition in the way that you did was welcome. You did a good job on that.	Implementation of new system in short turnaround	Broad range of participants	Fabulous discussions during MSR
The live meetings and discussions	There was a lot of learning in the meetings, driven by the diverse skills sets and	Transparency- fluid discussion and better understanding of non-eCQM measures	Transition from past vendor to yours and continuing to keep the measures in the forefront.

	experiences of the members.		
Engagement and interaction by all!	Diverse voices/input Not automatically accepting measures just because	Collaborative mutual learning opportunities as well as constructive discussions	Quick and furious attack of measures. Loved the participation and the public comment. Appreciated all the materials prepared by PQM as well.
Comments in Excel are not easy. A bit more in person discussion is helpful	The resources were well organized and easily accessible.	Getting patient and clinician input	we got through it all
The review materials and aggregated information was very helpful	Inclusive process.	The materials and resources have been very helpful in explaining the process.	welcoming environment for discussions
The exchange of ideas and views were outstanding. The decks with background data was presented in a way that provided the data to make sound and factual choices.			