

Consumer-Purchaser

DISCLOSURE PROJECT

Better information. Better decisions. Better health.

August 30, 2011

Donald Berwick, MD, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services

RE: Response to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012 Proposed Rule (CMS-1524-P)

Dear Dr. Berwick:

The 29 undersigned organizations are part of a collaboration of leading consumer, labor, and employer organizations committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment, and quality improvement. We appreciate the opportunity to comment on the Payment Policies Under the Physician Fee Schedule and other Revisions to Part B for CY 2012 Proposed Rule.

Physicians have a tremendous influence on how health care is delivered. They serve as key advisors to patients and make decisions that control 87% of personal health spending.¹ As the largest purchaser of health care, CMS plays a critical role in encouraging physicians to improve the quality and affordability of medical services and rewarding those that do. We urge CMS to quickly leverage the Physician Fee Schedule (PFS) programs to encourage physicians to pursue quality and value of services, rather than volume of care – and ultimately to advance the interests of patients and taxpayers. Swift action is needed in light of the growing concerns around the affordability of health care, sustainability of Medicare, and the ever present quality chasm.

We greatly appreciate the effort CMS is putting forth in developing and maintaining all the programs in the PFS and responsiveness to those who receive and pay for care. In particular, we are pleased with the increase in outcome and patient experience measures in these programs and recent steps in addressing problems with the Resource-Based Relative Value Scale. While these actions are positive, we call on CMS to be bolder. ***Ensuring programs and payment are designed to deliver better quality and more affordable care to consumers needs to be a higher priority.*** While making programs accessible to all physicians is a laudable goal, it should not be done at the expense of achieving real change.

¹ Sager A. and Socola D., "Health Costs Absorb One-Quarter of Economic Growth, 2000–2005," Data Brief No. 8, Boston, MA: Boston University School of Public Health, February 2005.

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What follows are recommendations on how to prioritize the needs of those who receive and pay for care while reducing the amount of effort physicians expend on measurement so they can devote more resources to their patients and delivering better, more affordable care. As detailed further in the Appendix, we encourage CMS to rapidly pursue a course to:

- **Use a parsimonious core set of measures that matter to patients across programs and evolves as better measures become available.** Employing a core set of high-value measures drives attention to areas of high impact and reduces confusion from the cacophony of measures, particularly in Physician Quality Reporting System. The core set should include cross-cutting measures applicable to any physician so all who want to can participate, as well as measures that apply to specific subsets of physicians. Patient experience, intermediate and other outcomes, and resource use should be the cornerstone for the initial set of cross-cutting measures. Areas in which to do an initial “deeper dive” include primary care, cardiology, endocrinology, and orthopedics.
- **Identify the ideal dashboard of measures and chart a course for reaching the destination.** We need a roadmap on how to fill in the gaps in measures so we can collectively make judicious use of resources. If a measure set cannot address a specific area due to a lack of measures or other limitations, a clear course should be charted out to address the gap.
- **Make improvements to the Resource-Based Relative Value System.** Payment reform will not reach its full potential if it continues to be based on a system that is inherently flawed. Thus, making improvements to fee-for-service payment to physicians while also implementing new payment systems is imperative to the affordability and sustainability of health care. This should include rebalancing payments between primary care and specialty services so that patients are more likely to receive the foundational care that can avoid riskier and more costly care. CMS should move from a system based solely on physician resources to considering patient needs and the interests of society as a whole in its determination of the relative value of different services. Moreover, when physician resources are considered, it should be based on the most efficient practices.
- **Align select program activities within Medicare and across other payers.** Alignment creates synergies across programs, reduces the amount of effort physicians expend on data collection, and ensures that we are all “rowing in the same direction.” Creating core measure sets for the Medicare program, of which a substantial portion is applicable to Medicaid and private payers, will go a long way to achieving these goals. Similarly, enabling electronic collection of clinical data will support more efficient and effective public reporting and value-based purchasing programs.
- **Focus on individual physicians, where variation in performance is most evident, and not just higher levels of aggregation, whenever feasible.** CMS will generate the greatest improvements if it promotes individual accountability, in concert with shared accountability. Individual accountability reinforces professional motivation for quality improvement, provides information for patients to use in choosing physicians, and identifies improvement areas that are masked by higher levels of aggregation. As we have seen with the Sustainable Growth Rate and other initiatives, incentives applied at the group level can be less effective.

In the Appendix, we provide specific suggestions on programs in the order they appear in the proposed rule. The above overarching recommendations serve as the basis for these comments. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, William Kramer, Executive Director for National Health Policy for Pacific Business Group on Health or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

AFL-CIO
The Alliance
American Benefits Council
American Hospice Foundation
Buyers Health Care Action Group
Center for Medical Consumers
Childbirth Connection
Consumers' CHECKBOOK/Center for the Study of Services
Dallas-Fort Worth Business Group on Health
Employers' Health Coalition
Employers Health Coalition, Inc.
Florida Health Care Coalition
Health Policy Corporation of Iowa
HR Policy Association
Indiana Employers Quality Health Alliance
Iowa Health Buyer's Alliance
The Leapfrog Group
Lehigh Valley Business Coalition on Health Care
Mid-Atlantic Business Group on Health
Midwest Business Group on Health
National Business Coalition on Health
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Northeast Business Group on Health
Pacific Business Group on Health
Puget Sound Health Alliance
PULSE of America
South Carolina Business Coalition on Health
St. Louis Area Business Health Coalition

APPENDIX

The following are comments from a combined consumer, labor, and purchaser perspective on issues and questions raised in the Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012 proposed rule. We appreciate your receptiveness to our comments and look forward to providing further input.

RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS)

Potentially misvalued services under the Physician Fee Schedule

Historically, CMS has relied heavily on recommendations from the American Medical Association's Relative Value Scale Update Committee (RUC) for relative value units. We greatly appreciate recent actions that signal greater independence from the RUC. For example, in the recent 5-Year Review of the Resource-Based Relative Value Scale (RBRVS) proposed rule, CMS accepted approximately two-thirds of the RUC's recommendations, a decline from the typical 90%. Also, in the proposed rule in which we are commenting, CMS recommends receiving annual public input on misvalued codes during the 60-day public comment period. We strongly encourage CMS to conduct public education to increase awareness of this opportunity should it be included in the final rule. Two other changes CMS should make to achieve greater independence from the RUC are:

1. We agree with MedPAC's suggestion of "collecting data on a recurring basis from a cohort of practices and other facilities where physicians and nonphysician clinical practitioners work" with the following amendment: it should be from a cohort of efficient practices and facilities. CMS should not be paying physicians at rates that include wasteful and inefficient care. As part of this process, CMS should develop a working definition of efficient practices and facilities.
2. We agree with MedPAC's recommendation that CMS develop a new, independent panel of experts to advise it on RVUs and the experts "include members who do not directly benefit from changes to Medicare's payment rates." Furthermore, we believe the majority of the panel should include not only experts who do not have a vested interest (e.g., medical economists, technology experts) but also those who are paying for and receiving health care (e.g., consumers and purchasers). The scope of this panel should go beyond the traditional definition of value of provider costs (e.g., physician resources) being the sole factor for payment and consider a much broader framework for value. CMS should consider patient needs and the interests of society as a whole in its determination of the relative value of different services. The new 'value' factor should consider such things like policy priorities, patient preferences, and Medicare's fiscal sustainability.

Undervaluation of primary care services

The increase in primary care payments outlined in the Affordable Care Act is only a short-term fix for a problem that needs a longer term solution. Medicare must begin reducing the gap between payment for specialists and primary care. In the near term, we strongly support CMS prioritizing the review of E/M codes so changes can be made in the CY 2013 Physician Fee Schedule. At the same time, CMS should review well-known overpriced specialty services.

Ultimately, improving the process of valuing services will require systemic changes (refer to previous section for suggestions).

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

Since 2007, the Physician Quality Reporting System (PQRS) has been a voluntary reporting program that provides an incentive payment to eligible professionals (EPs) who satisfactorily report data on quality measures to CMS. In 2015, the Affordable Care Act transitions PQRS into a penalty-based program. While there is an overabundance of discrete process measures that reflect basic competencies of care (and lack evidence linking them to improved outcomes), CMS recently included outcome measures. With the exception of the group reporting option, PQRS continues to require too little of EPs, who, for the most part only need to report on any three measures – a standard in place since 2007. Strengthening PQRS is important to all the measurement programs in the Physician Fee Schedule since CMS is using it as a building block for alignment. Below we provide recommendations for achieving a robust program.

Improve the current set of measures

- Create a core set of high-value measures that drives attention to areas of high impact and reduces confusion from the cacophony of measures. The measure set should be limited to those measures that emphasize where physicians should focus to achieve the goals set forth in the three-part aim. The core set should include cross-cutting measures applicable to any physician to ensure participation, engagement and accountability by all physicians in the Medicare program. Additionally, CMS should include measures that apply to specific subsets of physicians who account for a large fraction of spending and/or services (e.g., cardiology, gastroenterology, and orthopedics). Patient experience, intermediate and other patient outcomes such as functional status, and resources use (such as risk adjusted annual total cost of care) should be the cornerstone for the initial set of cross-cutting measures. As a step towards implementing a core set, CMS should require all physicians collect the same three high-value measures.
- Develop sets of measures that apply to a subset of clinicians. Focusing on cardiovascular conditions that are required for internal medicine, family practice, general practice, and cardiology is a good start. CMS should require reporting on more than one measure in this set and expand to other areas. This could be done through existing or new measure groups. CMS should work to rapidly define key outcome markers for prevalent medical conditions within a specialty. These outcomes should be the focus of measurement within the PQRS and for future inclusion in Meaningful Use requirements and the physician value-based payment modifier. Measures of process of care should be de-emphasized (either removed or down-weighted), and physicians should be accountable for outcomes of care; this moves away from micro-managing how physicians work to achieve outcomes and can substantially reduce reporting burdens.
- Remove measures of basic competencies as well as process measures not linked to outcomes and replace them, whenever available, with robust measures. See Table 1 at the end of this document for specific recommendations.
- Add meaningful measures that fill in current gaps. See Table 2 at the end of this document for specific recommendations.

- Give preference to HEDIS measures, where there are measures that overlap with the HEDIS content (e.g., controlling high blood pressure). Doing so will reduce data collection effort by providers and promote synergies between the public and private sectors. Many HEDIS measures can be collected via claims data and these measures have a long history in both the commercially insured and Medicare Advantage population.
- Use national standards as the primary source for measures. Measures endorsed by the National Quality Forum (NQF) should be the primary source for measures in federal programs. When non-NQF measures are used because NQF measures do not exist or are unduly burdensome, it should be with the understanding that they will be replaced by comparable NQF endorsed measures when available.
- Develop measures that will fill gaps in the measure dashboard and adhere to key criteria for robust measures. Refer to the attachment *Nine Criteria for Meaningful and Usable Measures of Performance* for more information.

Explore options for reliable reporting at the individual clinician level

- Expand the minimum sample size required for group practice reporting so information can also be reported at the individual physician level.
- Explore using a 0.70 reliability threshold as an alternate to minimum sample size. The minimum sample size for reliable reporting can vary considerably by measure for individual physicians. When reliabilities are lower, CMS should look at strategies to increase reliability by either compositing or using shrinkage estimates.

Fast track resolving issues with electronic transmission of Meaningful Use measures

Fostering the use of electronic health records is central to advancing efficient collection of clinical data. Contrary to original expectations, CMS will not be able to accept information for EPs on clinical quality measures electronically for the Meaningful Use program. We are deeply disappointed by this and urge CMS to quickly rectify the situation.

Maintenance of Certification “more frequently” requirement

As required by the Affordable Care Act, physicians are eligible for a 0.5% bonus payment add-on to PQRS for Maintenance of Certification (MOC) participation. At a minimum, clinicians must successfully complete one MOC program practice assessment each year to be eligible for the bonus. We support CMS’ proposal for Boards to determine how to meet the “more frequently than is required” clause in the law. CMS should require that this is done in consultation with consumers and purchasers. Additionally, we are very pleased the Part IV practice assessment includes a survey of patient experience. We strongly urge that CMS move toward requiring an NQF-endorsed patient experience survey for all providers. A growing body of evidence demonstrates that improving patient experience is directly linked to improvements in health outcomes.

ELECTRONIC PRESCRIBING (eRX) INCENTIVE PROGRAM

The Electronic Prescribing (eRX) Incentive Program was implemented in 2007 to provide incentive payments to eligible professionals for electronically prescribing medications for Medicare patients seen in their offices. Penalties for eligible professionals who are not successful e-prescribers begin in 2012. The eRX Incentive Program continues to have too low a bar for determining “successful electronic prescribers.” CMS should, at a minimum, require eligible professionals to electronically transmit more than 40% of written prescriptions, which is in line with the Meaningful Use incentive program. Additionally, CMS is proposing even lower standards for avoiding a payment adjustment than for successful electronic prescribers. Individual EPs would only need to report that they generated at least one electronic prescription for 10 patient encounters. However, requirements for receiving the bonus and avoiding the payment adjustment should be the same

PHYSICIAN COMPARE

The ACA mandates the creation of Physician Compare to help Medicare beneficiaries make better choices about whom they choose to be their physician and provide transparency in physician performance. The ACA also mandates that the website be populated with information on: patient health outcomes, functional status, care coordination and transitions, resource use, efficiency, patient experience, and patient, caregiver and family engagement. CMS is slow in moving to measures that matter to beneficiaries and providing performance information for individual physicians. Currently, there is a deficit in existing measure sets that are fully operational today to enable this; as such, CMS should be investing in the development/refinement of measures to create this capability.

We are disappointed that, for 2013, CMS plans to make only group practice performance results from PQRS available on the website, which is too high of a level of aggregation to be truly meaningful to patients in making choices about where to receive care. Consumers need and want information how well individual physicians care for their patients. Practice group level data is not always representative of an individual physician’s performance because the way physicians within the same group practice care for their patients can vary significantly. Furthermore, individual physicians greatly impact the care that a patient receives. Making comparative information available on individual physician performance within a practice can also be a powerful motivator for change in a team-based context. CMS should implement our recommendation under the PQRS section for increasing reliable reporting of performance at the individual physician level.

Physician Compare needs to be populated with measures that matter to patients. The PQRS group practice measure set includes a large number of process measures, which may be helpful to physicians for quality improvement purposes but do not resonate with patients in what matters to them, such as whether they have improved functioning, fewer complications, reduced time in the hospital, and lower morbidity and mortality. The agency should shift rapidly away from measures of process and center its work on a narrower set of high-value measures such as those required by ACA for this program. CMS should publicly report this information as soon as possible.

PHYSICIAN FEEDBACK PROGRAM

CMS initiated the Physician Resource Use Measurement & Reporting Program (otherwise known as the Physician Feedback Program) in 2009. The program provides confidential feedback reports to physicians on the resources they use to furnish care to Medicare beneficiaries and the quality of care they supply. The reports also show physicians how they are performing relative to their peers. The ACA requires that CMS develop a Medicare episode based grouper to support this program. CMS anticipates that the approach used in the Physician Feedback reports will serve as a way to test how to develop and implement the Value-Based Physician Payment Modifier, which is covered in the next section. Below are comments on the Physician Feedback Program.

- CMS will apply a set of 28 claims-based measures (12 are HEDIS measures) to individual clinicians in 2011. We appreciate that the set includes measures of intermediate outcomes, care coordination, and adverse drug events.
- We support CMS' plans to include measures of preventable hospital admissions (for 6 ambulatory care sensitive conditions) and hospital utilization (for patients who have chronic conditions) in its reports to group practices. We also support CMS' plans to use per capita costs for both individual physicians and group practices for chronic conditions, as long as they are risk-adjusted across all Medicare beneficiaries.
- CMS plans to employ PQRS measures in the Feedback Program in 2012 and in future years to promote alignment among federal programs. While we support streamlining programs, we are concerned about the dearth of impactful measures in PQRS, as we noted in our earlier comments. The desire for alignment should be balanced with the need for impactful measures of care. Also, PQRS allows most individual clinicians to report on any three measures, undermining the ability of Feedback reports to provide physicians with information on how they compare relative to other physicians in quality of care. We recommend PQRS require the same three measures of all clinicians.
- See Table 1 at the end of this document for recommendations on measures to remove from the program and Table 2 for measures to add to the program. In particular, we encourage CMS to create a more robust program for physicians outside of primary care.
- CMS plans to stratify physicians by specialty for cost and quality. We oppose the intent to only compare physicians in the same specialties. Primary care physicians or other specialists may practice more efficiently for patients with a given condition. CMS, as a result, should include primary care physicians and relevant specialists in the reference group.
- CMS is exploring alternative attribution methods with the goal of better matching patients to physicians on quality and resource use. In the past, CMS has used E/M services and a minimum cost threshold. But CMS suggests that cost of service rules, for example, may better apply to physicians who commonly furnish surgical procedures or interventions, especially those that are high volume and/or high cost. CMS should consider a more inclusive attribution approach such that if a service is relevant to that provider, he or she is included (e.g., multiple physician attribution approach to ensure the right care is provided).

VALUE-BASED PAYMENT MODIFIER

The Affordable Care Act (ACA) requires the establishment and implementation of a Value-Based Payment Modifier (Value Modifier) that provides for differential payments to physicians under the physician fee schedule based upon the quality of care furnished compared to cost. The law stipulates that this “value” modifier must be implemented in a budget-neutral manner. The ACA requires a transitional approach to implementing the Value Modifier, beginning with application to specific physicians and groups of physicians on Jan. 1, 2015 and transitioning to all physicians no later than Jan. 1, 2017. This program is an important component to transitioning Medicare to pay physicians based on value. With the exception of measures, CMS is in the early stages of designing this program and we offer the following goals to guide development:

- Tie a substantial portion of physician payments to the Value Modifier, and increase that portion over time.
- Place greater emphasis on achieving cost containment since all the other Medicare incentive programs focus on quality improvement.
- Provide rewards on a limited number of measures that have high impact and are important to patients (e.g., patient experience and key outcomes like functioning, morbidity, and mortality).
- Apply the value modifier to individual physicians, whenever feasible, to increase opportunity for affecting change.
- Promote alignment between public and private sector initiatives.

The ACA requires that CMS publish, by January 2012, which quality and cost measures it will use for the Value Modifier in 2015. CMS is interested in using a core set of quality measures that consist of the PQRS “core” set (prevention of cardiovascular conditions), the PQRS measure set for group practices, and the meaningful use measures (including core measures, alternate core measures, and the 38 additional measures). We appreciate CMS’ efforts to align with other federal programs, but to facilitate rapid improvements in care and judicious use of public funds, it is extremely important these measures are high value and not low value for the sake of alignment. For example, some low value measures focus on processes of care rather than outcomes or functioning. The modifier should have a more narrow focus and reward what matters.

We applaud the agency’s strong interest in measures of outcomes (with a preference for those that can be calculated from Medicare claims data), care coordination and transitions, patient safety, patient experience, and functional status. These are critical to advancing patient care. CMS plans to address more of these areas in future iterations of the Value Modifier. We support many of the concepts that CMS identified in these areas (e.g., all-cause hospital readmissions, preventable hospital readmissions, ER use for ambulatory sensitive conditions, measures of complications, etc.), as well as intermediate outcomes for chronic conditions such as hypertension, coronary heart disease, heart failure, chronic obstructive pulmonary disorder, and depression. In further defining these measures, CMS should place a heavy emphasis on addressing how well specialists perform in these areas of care.

CMS is asking for feedback on cost measures. We support measures of risk-adjusted total per capita cost and per capita cost for beneficiaries with COPD, heart failure, CAD, and diabetes. In fact, we think this could be done for all types of patients. These cost measures would be used until the agency transitions to the episode grouper.

TABLE 1: Measures that should be removed from CMS physician programs

Measure	Medicare Program	Reason	Replacement, if available
Diabetes Mellitus: Dilated eye exam in diabetic patient	PQRS # 117/Value-Based Payment Modifier/Physician Feedback Program #13	Measure of basic competencies.	
Diabetes Mellitus: Foot exam	PQRS #163 /Value-Based Payment Modifier	Measure of basic competencies.	
Diabetes Mellitus: Urine screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	PQRS #11/Value-Based Payment Modifier 9/ Physician Feedback Program #15	Measure of basic competencies.	
Back Pain: Initial Visit	PQRS #148	This measure only asks whether a physician <u>documented</u> in the medical record that the initial visit covered certain elements (e.g., pain assessment, functional status, patient history, etc.).	Overall, the clinical measures of low back pain that CMS proposes to use don't effectively address overuse. Instead, CMS should use NCQA's claims-based measure of "Low back pain: use of imaging studies" (NQF #0052). This measure is proposed for the value-based payment modifier.
Back Pain: Physical Exam	PQRS #149	This measure simply asks if a physician conducted a physician examination if a patient was experiencing back pain. It reflects a commonsense practice that does not need to be measured.	
Coronary Artery Disease (CAD): Symptom and Activity Assessment	PQRS #196	This measure simply requires that a physician "assess" a patient's health status if they have CAD.	
Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin	PQRS #21	Measure of basic competencies.	CMS' PQRS measure group for perioperative care focuses solely on process measures when there should be measures of outcomes that capture whether infection or venous thromboembolism occurred.
Heart Failure: Left Ventricular Function (LVF) Assessment	PQRS #198/Value-Based Payment Modifier	It is a "check-the-box" measure that simply assesses whether the clinician completed an assessment. Rather, the measure should report the patient's health status so that the clinician can determine whether the patient is improving over time.	

Heart Failure: Left Ventricular Function (LVF) Test	PQRS #228/Value-Based Payment Modifier	This is a standard of care measure and should not be included.	
Heart Failure: Weight Measurement	PQRS	This is a standard of care measure and should not be included.	
Community-Acquired Pneumonia (CAP): Vital Signs	PQRS #56	This measure only asks the physician to check a patient's vital signs. This is a very basic expectation of patient care.	
Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	PQRS #57	This measure simply asks physicians to assess a patient's oxygen levels.	
Asthma: Asthma Assessment	PQRS #64/Value-Based Payment Modifier	This measure only asks a physician to "assess" a patient's COPD. The goal should be to report the outcome of care.	Minnesota Community Measurement's measure of Optimal Asthma Control factors in critical outcomes (e.g., patient survey of asthma control, ED visits, hospitalization, etc.)
Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	PQRS #51/Value-Based Payment Modifier/Physician Feedback Program #2	The clinician is only asked to "evaluate" a patient's health status.	
Acute Otitis Externa (AOE): Topical Therapy	PQRS #91	We question whether this measure even meets the "clinical importance" test, let alone meaningfulness to consumers.	
Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers	PQRS (newly proposed)	Measure of basic competencies and poorly specified.	
Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers	PQRS (newly proposed)	Measure of basic competencies.	
Coronary Artery Disease (CAD): Symptom Management	PQRS (newly proposed)	We are doubtful that this measure has any substantive link to care coordination. Additionally this measure only requires that a clinician "document a plan of care to manage angina symptoms." This check-the-box measure will not improve patient outcomes. Rather, the goal of this measure should be report whether the patient's angina is getting better or worse.	
Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	PQRS (newly proposed)	This is a basic competency of care.	

Primary open angle glaucoma (POAG): Optic Nerve Evaluation	PQRS #12/Value-based Payment Modifier	This is a basic competency of care.	
Hypertension: Plan of Care	PQRS #235	To align with the private sector, CMS should use the NCQA measure in this space. PQRS #235 is also problematic because it combines blood pressure control and plan of care into the same denominator.	NCQA's measure of "Controlling high blood pressure" blood pressure control for patients with hypertension (PQRS# 0018)
Blood Pressure Control	PQRS (newly proposed for PQRS Elevated Hypertension Measures Group)	CMS should align with the private sector and use the NCQA measure in this space.	NCQA's measure of "Controlling high blood pressure" blood pressure control for patients with hypertension (PQRS# 0018)
Improvement in Patient's Visual Function within 90-Days Following Cataract Surgery.	PQRS (newly proposed)	PQRS already contains a similar measure -- 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery, which is currently a PQRS measure (PQRS#191). CMS should avoid duplicating this measure.	

Table 2: Measures that should be added to CMS physician programs

Measure	Medicare Program	Additional Comments
Diabetes Mellitus: Tobacco Non-Use	PQRS	This measure importantly captures whether a patient achieved “tobacco-free status.” All too often, measures of tobacco use only include an “assessment” and “counseling,” which fail to report whether a patient quit smoking. Use it to replace PQRS measure #226.
Patient Satisfaction within 90-Days Following Cataract Surgery.	PQRS	We support the measure concept. A recommendation on the measure will be provided when the technical specification is available for review.
Rate of Open AAA Repair without Major Complications (discharged to home no later than post-operative day	PQRS	We support the measure concept. A recommendation on the measure will be provided when the technical specification is available for review.
Rate of EVAR without Major Complications (discharged to home no later than POD #2).	PQRS	We support the measure concept. A recommendation on the measure will be provided when the technical specification is available for review.
Rate of Carotid Endarterectomy for Asymptomatic Patients, without Major Complications (discharged to home no later than post-operative day #2).	PQRS	We support the measure concept. A recommendation on the measure will be provided when the technical specification is available for review.
Low-back pain: Use of Imaging Studies	Value-Based Payment Modifier	Assesses important area of overuse
Preventable hospital admissions (for diabetes, bacterial pneumonia, dehydration, COPD, urinary tract infection , CHF)	Physician Feedback Program	We encourage CMS to include other conditions that are covered in the AHRQ PQIs, such as asthma.
Follow-up After Hospitalization for Mental Illness	Physician Feedback Program #4	
Use of High-Risk Medications in the Elderly	Physician Feedback Program #6	
Potentially harmful drug-disease interactions in the elderly	Physician Feedback Program #7	
Clinician/Group CAHPS survey	PQRS, Physician Feedback Program, and Value-Based Payment Modifier	Patient experience is a key piece of the “three-part aim.” Including this measure will align with CMS’ Shared Savings Program.
National Health Service’s Patient Reported Outcome Measures of hip and knee replacement	PQRS, Physician Feedback Program, and Value-Based Payment Modifier	These are well-vetted measures that capture the patient’s perspective about the end result of care.
CMS Episode Grouper	Value-Based Payment Modifier, Physician Feedback Program	We support this concept. The Episode Grouper is under development. A recommendation on the measures will be provided when the technical specification is available for review.
VR-12	Physician Feedback Program, and Value-Based Payment Modifier	

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DRAFT

AUGUST 2011

Nine Criteria for Meaningful and Usable Measures of Performance

EXECUTIVE SUMMARY

Consumers, purchasers, policy makers, and other stakeholders seek improved quality and affordability in our health care system. A strong set of meaningful and usable performance measures is an essential tool in this pursuit. Currently, there are not enough of these measures, which are vital to:

- Determine whether new models for care delivery and payment are substantially improving health outcomes.
- Help consumers choose health care providers and treatments.
- Engage patients in decisions about their care.
- Give providers information that supports their efforts to improve care.
- Enable purchasers and health plans to reward providers based on quality of care and patient outcomes rather than on volume.

More ambitious standards for measures are required to meet these growing demands for more and better information.

In response, the Consumer-Purchaser Disclosure Project (CPDP) developed **nine criteria** for meaningful and usable measures. These criteria reflect the perspectives of consumers and purchasers, and are intended to guide the development, endorsement, and use of performance measures. This is critical, as performance measures must address the needs of those whom the health care system is intended to serve and those who pay the price for poor and inefficient care – *consumers and purchasers*.

These criteria are:

1. Make consumer and purchaser needs a priority.
2. Use direct feedback from patients and their families to measure performance.
3. Build a comprehensive “dashboard” of measures.
4. Focus on areas of care where the potential to improve health outcomes and increase the effectiveness and efficiency of care is greatest.
5. Ensure that measures generate the most valuable information possible.
6. Assess patient and provider follow-through.
7. De-emphasize documentation (check-the-box) measures.
8. Measure the performance of providers at all levels (e.g., individual physicians, medical groups, ACOs, etc.)
9. Collect data efficiently.

Nine Criteria for Meaningful and Usable Measures of Performance

1 MAKE CONSUMER AND PURCHASER NEEDS A PRIORITY.

PROBLEM:

Health care reform asks consumers and purchasers to take a larger role in improving care (e.g., patients should actively participate in their care and be able to select providers who meet their needs; and purchasers should offer providers the right incentives to pursue value instead of quantity of care). Unfortunately, only a small number of the provider performance measures currently available or in use supply adequate information for consumers and purchasers to take such actions.

OPPORTUNITY:

Those working in measurement should involve consumers and purchasers meaningfully so that their needs are a priority in decisions related to measure development, endorsement, and use at national and local/regional levels.

2 USE DIRECT FEEDBACK FROM PATIENTS AND THEIR FAMILIES TO MEASURE PERFORMANCE.

PROBLEM:

Most measures currently in use rely on administrative and clinical data, which reflect the viewpoints of clinicians and the health care system. These measures do not capture the perspective of the person receiving health services, who is often in the best position to evaluate their effectiveness.

OPPORTUNITY:

More measures should assess outcomes and effectiveness of care, as experienced by patients and their families. These should include measures of patients' understanding of treatment options and care plans, and their feedback on whether care made a difference. Measure developers should consider how patient surveys can be administered electronically as health plans and providers connect electronically with their members/patients.

3 BUILD A COMPREHENSIVE "DASHBOARD" OF MEASURES.

PROBLEM:

All too often, measures have focused on discrete treatment processes that may be meaningful to providers. But consumers and purchasers are asking for a wide range of measures that capture whether the care provided made a difference for the patient, reflected that patient's preferences, and was delivered efficiently.

OPPORTUNITY:

The goal should be a comprehensive dashboard of measures that makes it possible to assess the effectiveness and efficiency of care. Such a dashboard will allow us to hold individual physicians, accountable care organizations, care teams, hospitals and other providers accountable for how well they care for their patients, particularly those with multiple chronic conditions. We call upon measure developers and endorsers to make every effort to fill in the dashboard.

The diagram on the next page shows a dashboard that covers the full spectrum of measures, categorized by the three-part aim of achieving better health, better care, and lower cost.¹ **Appendix 1, on page 9, provides an example of how a comprehensive dashboard of measures might look for maternity care.**

The Patient-Centered Measure Dashboard

Better Health	Better Care	Lower Cost
<ul style="list-style-type: none">• Clinical outcomes of treatment – The results of care that are typically reported by a doctor or other clinician. Examples of clinical outcomes include treatment complications, morbidity, mortality, preventable readmissions, signs and symptoms, and laboratory determinations of physiologic values.• Patient-reported outcomes of treatment – Assessments by patients of whether treatment is “working.” These may include patients’ reports of well-being, resolution of pain, improved functioning, etc.	<ul style="list-style-type: none">• Appropriateness of care (i.e., underuse and overuse of diagnostic and treatment resources – this includes process measures that effectively assess underuse and overuse* – and misdiagnosis) – Underuse and overuse focus on whether the net clinical benefit of a given treatment or procedure for a given patient justifies the expenditure of resources, exposure of patient to radiation, and so forth (potential benefit versus potential risks). Misdiagnosis refers to a wrong diagnosis.• Patient experience with care – Captures patients’ perspective on their experience with a provider’s care (i.e., how well a doctor communicates, knows their patients, coordinates care, and provides quick access to appointments and care, and whether the outcome reflects a patient’s expectations).• Patient activation and engagement – Measures the extent to which providers and systems actually give patients and their caregivers the guidance they need to participate effectively in their care and thus to benefit from it optimally. Examples include whether a provider involves patients in creating care plans; whether both providers and patients follow through on care plans; and whether patients understand their treatment options and are well equipped for self-management.• Care coordination and care transitions – Assesses how well providers work together to provide seamless care to a patient as he or she moves from one care setting to another.• Effective use of health information technology (HIT) by patients and care providers – Evaluates whether HIT helps patients become more engaged in their care and/or improves how providers deliver care.• Patient safety – Assesses the use of processes and management practices proven to promote patient safety, ranging from hand hygiene to medication reconciliation to effective teamwork.	<ul style="list-style-type: none">• Total cost to and expenditures by (1) the patient; (2) the insurer; and (3) the health care system:<ul style="list-style-type: none">• Over the course of a year• Per case or acute episode• Efficiency of resource use, including key utilization metrics such as emergency department visits, hospital admissions, and readmissions. <p><i>If a measure set cannot address a specific area due to current data or other technical limitations, a clear course should be charted out to address it in the near term.</i></p>

**Where appropriate, process measures should be combined to create composites that reflect the set of processes that should be completed. And, whenever possible, composite measures should be based on a patient-centered approach – i.e., the patient has received all indicated tests and treatments known to provide significant positive health effects for their condition.*

Many of the identified measure types may fit into more than one section of the three-part aim.

Nine Criteria for Meaningful and Usable Measures of Performance

4 FOCUS ON AREAS OF CARE WHERE THE POTENTIAL TO IMPROVE HEALTH OUTCOMES AND INCREASE THE EFFECTIVENESS AND EFFICIENCY OF CARE IS GREATEST.

PROBLEM:

Measure development, endorsement, and use efforts don't always focus on areas of care with the greatest potential to improve quality and use resources effectively.

OPPORTUNITY:

To ensure the best possible return on investment, measure sets should:

- Focus on areas of practice with high frequency, high cost, wide variation, disparities in delivery, and/or evidence of care that is frequently unwarranted.
- Address leading causes of morbidity, mortality, and disability.
- Assess care of patients with multiple chronic conditions, a leading cost driver.
- Cover areas identified by the Institute of Medicine (IOM) as needing significant improvement: safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness.
- Meet the four evaluation criteria used by the National Quality Forum (NQF):² (1) importance to measure and report – especially to consumers and purchasers, (2) scientific acceptability of the measure properties, (3) feasibility, and (4) usability – especially by consumers and purchasers.
- Include measures of processes of care **only** if they have strong, evidence-based links to key outcomes and are consistent with current clinical guidelines.

We encourage decision makers to use priorities identified by national organizations to guide work in measurement. Collectively, these priorities cover a breadth of areas important to consumers experiencing different health needs (e.g., preventive, acute conditions, chronic conditions). Such organizations include:

- The **National Priorities Partnership**.
- NQF, in its **prioritization** for measure development and endorsement of the top 20 conditions with a high impact on Medicare.
- **Measure Applications Partnership (MAP)**.³
- The federal government's **National Quality Strategy**.

5 ENSURE THAT MEASURES GENERATE THE MOST VALUABLE INFORMATION POSSIBLE.

PROBLEM:

Measures are not always constructed in the best way to aid decision-making by consumers, purchasers, health care providers, and policy-makers.

OPPORTUNITY:

A. Include all patients in the calculations on which measures are based, unless there is a good and specific justification for omitting certain categories of patients.

Measure definitions and applications often exclude certain patients from calculations of providers' performance. This happens in two ways: exclusions and exceptions.

- **Exclusions occur** when a measure developer excludes patients with specific conditions from the denominator of a measure. This is appropriate when it is based on clinical logic: for example, a measure of whether a physician provides mammography screening to women would not include a patient with a bilateral mastectomy (a

Nine Criteria for Meaningful and Usable Measures of Performance

woman who had her breast tissue removed and therefore does not require the screening) in the denominator.

- **Exceptions occur** when a source of the measure (e.g., a provider) removes patients from the denominator population based on clinical judgment or reasons other than clinical appropriateness. For example, clinicians may remove patients who, for whatever reason, decline a specific treatment option.

Exclusions and exceptions are *acceptable when they are evidence-based, highly specific, and explicitly defined*. This criterion will ensure that the removal of a patient from calculations of a provider's performance is appropriate and, moreover, the exact reason for the removal will be clear in an audit. Having rigorous parameters will also result in more informative data. Exceptions with extremely broad designations, such as "patient reasons" and "system reasons," should not be acceptable.

B. Use statistical standards that allow variations in care to show through.

Measures of outcomes and resource use typically incorporate statistical techniques, such as risk adjustment, risk-stratification, setting standards for reporting through confidence levels, and so forth. However, the quest for a "pure" measure (e.g., striving for perfection over practicality) sometimes washes away important variations in care. Measures may be *over-adjusted* for risk and/or set overly stringent statistical standards, such as requiring a 95% certainty that the results precisely represent a provider's performance on a measure or labeling most providers as "average" when large variations in care are known to exist. This is problematic, because patients and purchasers need information that distinguishes performance among providers.

C. Capture data for disparities analysis.

Those who collect measures should include basic demographic information, such as race, ethnicity, language, gender, disability, and socioeconomic status, for all patients. This will provide important information to help address disparities.

D. Capture lab values and vital signs on a continuous scale.

Actual lab values and vital signs that represent valuable intermediate outcomes in treatment (e.g., LDL, HbA1c, blood pressure) should be captured so that the **exact** outcome can be collected. Often intermediate outcome measures are structured in a "yes" or "no" form, otherwise known as binary measures. An example is whether a patient with diabetes has "controlled blood sugar," meaning that an HbA1c level of less than 8% (or 7% or 9%) has been achieved. These binary measures generally ask whether the outcome of care meets a threshold based on guidelines or opinions that are often subject to change. For measures like these, data should be captured on a continuous scale so that thresholds can be adjusted without needing to recapture the data from the source. For example, the exact HbA1c value would be captured (e.g., 7.6%). Knowing the exact value of the outcome for each patient allows:

- Different thresholds to be set.
- Better evidence to inform clinical guidelines and identify which treatments work best for which patients.
- Providers to focus their improvement efforts.

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6 ASSESS PATIENT AND PROVIDER FOLLOW-THROUGH.

PROBLEM:

Most measures are process measures, which assess whether a doctor wrote a prescription, referred the patient to another clinician, recommended the patient take a test, developed a care plan, etc. But consumers and purchasers also need measures of follow-through. Did the doctor and the patient's care team actually follow the care plan, and did the patient fill the prescription, have the test, or see the referred clinician?

OPPORTUNITY:

Measures of physician orders and care plans may be appropriate indicators of the extent to which the physician is following clinical guidelines, but they should be paired with measures of adherence to the prescribed/recommended treatment (e.g., prescriptions ordered with prescriptions filled, tests ordered with test completion and results reported, care plan developed and followed). Shifting to a patient-centered perspective requires that measures be developed and specified to allow for data collection from the patient, including assessing the extent to which patients understand and follow recommended care. Measures of adherence will reveal whether or not what should have happened for the patient actually happened. Providers should be held accountable for following through with their patients and doing all they can to help their patients to do their part.

7 DE-EMPHASIZE DOCUMENTATION (CHECK-THE-BOX) MEASURES.

PROBLEM:

"Check-the-box" measures document the occurrence of evaluation, assessment, counseling, care plans, and other steps by a provider, but tell us little about the quality of care provided or its outcomes. For example:

- Current measures of whether a clinician provided counseling on smoking cessation – an important element in caring for individuals and populations – don't reveal how effective the counseling was.
- Measures of whether a physician performed an evaluation of a patient's ability to walk after hip surgery don't tell us whether the surgery actually made a difference. Rather, we need the results of the evaluation.

In fact, there is a poor relationship between such measures and patient outcomes.⁴ And when a measure is defined as a simple "check-the-box" (yes/no) item, it is often subjective and easy to "game."

OPPORTUNITY:

- Ask the patient to provide feedback on the quality of the interaction with the physician on particular issues (e.g., smoking cessation); and in the longer term, determine whether the patient's behavior actually changed in the appropriate direction (e.g., whether the patient quit smoking).
- Report the results, not the occurrence, of evaluations and assessments.

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8 MEASURE THE PERFORMANCE OF PROVIDERS AT ALL LEVELS (E.G., INDIVIDUAL PHYSICIANS, MEDICAL GROUPS, ACOs, ETC.)

PROBLEM:

Many argue that measures, especially those involving patient outcomes, should only be applied at a higher level in the chain of care providers (e.g., at the level of the practice group, the ACO, etc.) rather than at the level of the individual physician. But consumers need to select individual physicians to be a part of their care team, even where team-based practice occurs.

OPPORTUNITY:

Performance should be measured at all levels, including the individual physician level, when sample sizes are sufficient. Consider that:

- Individual physicians make decisions that control 87% of personal health spending.⁵
- Data on practice groups do not always well represent an individual physician's performance. The way physicians within the same group care for their patients can vary significantly, and individual physicians greatly impact the care that a patient receives.⁶

Even where sample sizes are small, performance information can be very valuable to physicians themselves to help them accelerate quality improvement. While patients and system factors related to the physician's practice setting also affect clinical performance and its outcomes, we should measure performance and, once adjusted for critical patient risk factors, attribute it jointly to individual physicians, their team, and the system they practice in. In other words, we subscribe to a concept of **shared accountability**.

9 COLLECT DATA EFFICIENTLY.

PROBLEM:

Providers often raise issues about the amount of effort it takes for them to collect performance data.

OPPORTUNITY:

Ideally, performance measures should be based on the same data that clinicians use to care for their patients. Specifications should call for measures to be populated with electronic data already collected and used for patient care. Where the data do not exist in electronic form today, there should be a clearly articulated path for future electronic collection and submission of data by increased reliance on electronic health records, as well as broader efforts by specialty societies, hospitals, nursing homes, and others to collect electronic data. Measure developers should also consider basing measures on clinically enriched administrative data when possible. Claims data will continue to be an important source of information on the services provided, even when widespread adoption of EHRs occurs.

However, the desire to avoid encumbering physicians with data collection must be balanced with the tremendous need that patients, purchasers and other stakeholders have for information. Patients face challenges every day when trying to navigate the health care system, including choosing a provider, trying to find affordable care, and determining what treatment will be best for them. At another level, purchasers must deal with the increasingly out-of-control cost of care and the need to reward higher-performing providers to spur better care.

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¹ Many of the identified measure types may fit into more than one section of the three-part aim.

² NQF is a nonprofit organization that uses a consensus process to engage multiple stakeholders in measure standardization at the national level.

³ MAP is a public-private partnership convened by NQF. MAP was created for the explicit purpose of providing input to the Department of Health and Human Services on the selection of performance measures for public reporting and performance-based payment programs.

⁴ Chassin M., Loeb J., Schmaltz S., and Wachter R., "Accountability Measures – Using Measurement to Promote Quality Improvement," *New England Journal of Medicine*, June 2010. <http://healthcarereform.nejm.org/?p=3580>

⁵ Sager A. and Socola D., "Health Costs Absorb One-Quarter of Economic Growth, 2000-2005," Data Brief No. 8, Boston, MA: Boston University School of Public Health, February 2005. <http://dcc2.bumc.bu.edu/hs/Health%20Costs%20Absorb%20One-Quarter%20of%20Economic%20Growth%20%202000-05%20%20Sager-Socolar%207%20February%202005.pdf>.

⁶ Rodriguez et al, "Attributing Sources of Variation in Patients' Experiences of Ambulatory Care," *Medical Care*, Vol. 47, No. 8, August 2009.

ABOUT THE CONSUMER-PURCHASER DISCLOSURE PROJECT

The Consumer-Purchaser Disclosure Project is a coalition dedicated to improving the quality and affordability of health care in America for consumers and health care purchasers. The project's mission is to put the patient in the driver's seat – to share useful information about provider performance so that patients can make informed choices and the health care system can better reward the best performing providers. The coalition is comprised of leading national and local consumer organizations, employers and labor organizations. The Consumer-Purchaser Disclosure Project is funded by the Robert Wood Johnson Foundation along with support from participating organizations.

For more information contact info@healthcaredisclosure.org or visit our website at www.healthcaredisclosure.org.

Appendix 1: Example of a Comprehensive Dashboard of Measures for Maternity Care

PRENATAL
(Outpatient setting)

DELIVERY
(Inpatient setting)

POSTPARTUM
(Inpatient and outpatient setting)

PATIENT-REPORTED OUTCOMES OF TREATMENT

- Health status after delivery (e.g., presence of pain and/or infection, presence of postpartum depression) 4-6 weeks post discharge*
- Effective treatment for maternal morbidities (e.g., pain and/or infection, postpartum depression)*

PATIENT EXPERIENCE WITH CARE

- Patient experience of care* (e.g., CAHPS modified for maternity care)



PATIENT ACTIVATION AND ENGAGEMENT

- Patient receives high-quality, understandable information about impact of interventions (e.g., C-section, induction)*
- Effective use of shared decision-making*
- Patients with previous C-section are offered a VBAC if available (either directly or through referral)*
- Patients are offered a range of options for pain management (e.g., non-pharmacological options vs. pain medications such as epidurals, spinal analgesia, narcotics, etc.)*
- In active labor, mother has right to self-determination (i.e., through shared decision-making)



CLINICAL OUTCOMES OF TREATMENT

- Healthy term newborns
- Term newborns with hospital-acquired conditions
- Maternal complications (e.g., hemorrhage, infections, DVT)
- Exclusive breastfeeding
- Maternal and newborn readmissions



Appendix 1: Example of a Comprehensive Dashboard of Measures for Maternity Care

PRENATAL

(Outpatient setting)

DELIVERY

(Inpatient setting)

POSTPARTUM

(Inpatient and outpatient setting)

CARE COORDINATION AND TRANSITIONS

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Patient preferences shared with entire care team • Information exchange between patient's primary physician and delivering provider on patient's health needs | <ul style="list-style-type: none"> • Adherence to patient preferences* • Prenatal record available at the birth site (should include patient's delivery preferences) | <ul style="list-style-type: none"> • Maternity care record shared with patient's primary care physician (e.g., patient with gestational diabetes would benefit from this sharing of information) |
|--|--|---|

APPROPRIATENESS OF CARE

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Screening for domestic abuse and substance abuse • Advice and appropriate referrals for those who are smoking and/or engaging in substance abuse • Patient receives selected essential prenatal care¹ | <ul style="list-style-type: none"> • Spontaneous births and labor (a composite) (e.g., no induced labor, augmented labor, assisted delivery, or Cesarean section) • VBAC for low-risk women • Low-risk C-section in first births • Elective delivery between 37 and 39 weeks • Elective induction under 41 weeks • Use of episiotomy • Healthy newborns admitted to the NICU | <ul style="list-style-type: none"> • Skin-to-skin contact in the first hours after birth |
|--|---|---|

TOTAL COST TO AND EXPENDITURES BY (1) THE PATIENT; (2) THE INSURER; (3) AND THE HEALTH CARE SYSTEM/EFFICIENCY OF RESOURCE USE

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Cost of prenatal care | <ul style="list-style-type: none"> • Cost of delivery-associated care (e.g., physician, hospital, midwife, birth center) – covering episode of care for mother and baby • Length of stay (mother and baby) | <ul style="list-style-type: none"> • Cost of newborn (prior to hospital discharge) • Hospital readmission (mother or baby) |
|---|--|--|

Note: Identified elements of maternity care can apply to more than one domain

*Elements that could be captured through a patient survey

¹For example, prenatal care should begin within the first ten weeks and include antenatal corticosteroids for accelerating fetal lung maturation for women at risk of preterm birth.

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