Performance Measure
Harmonization
A Step-by-Step Guide
Introduction

Measures abound in healthcare, where they are designed to analyze performance on myriad aspects of care, including those pertinent to clinician- and facility-level performance. The consistent growth in development and refinement of measures raises a question about whether we can be certain that each measure evaluates something different, while being aligned in a way that reduces the burden of implementation.

Measure harmonization can be defined using the National Quality Forum’s (NQF) measure evaluation criteria:

Measure harmonization refers to the standardization of specifications for related measures with the same measure focus [...] ; related measures with the same target population [...] ; or definitions applicable to many measures [...] so that they are uniform or compatible, unless differences are justified (e.g., dictated by the evidence). [...] The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources (NQF, 2011).

This definition and explanation were specifically developed as guidance for measures going through the NQF endorsement process, yet still address a topic that impacts measures outside of the scope of that process. It also can be applied to the issue of harmonization as a whole.

While there are existing resources which aim to facilitate a more standardized approach to measure development - including the Centers for Medicare and Medicaid Services (CMS) Measures Management System Blueprint (Blueprint), the Quality Data Model (QDM), and Clinical Quality Language (CQL) for electronic measures (see Appendix D) - there are still significant gaps in how information is collected and used to report clinical quality measures.

Background

Measure harmonization, at a high level, is the process of evaluating related measures and engaging in activities which would create a common definition for the measures’ scope and/or specifications. Measure harmonization is vital to ensure that we avoid both developing duplicative measures and creating unnecessarily unique definitions for clinical concepts required in measures. As a measure developer and steward, PCPI often hears of the increased burden imposed by measures that may appear to be of a similar nature or have shared clinical information, but in fact cause a great deal of manual effort to implement as a result of differences in the characterization of clinical concepts or storage of patient information. Without a common approach to measure harmonization, each measure development effort starts from scratch, without leveraging work already completed, and creates a plethora of seemingly similar, yet different measure concepts.

As referenced above, in 2011, the NQF published a document which included guidance related to harmonization. Subsequently, in 2016, NQF published a report based on the extensive research they conducted on value sets contained in the National Library of Medicine’s (NLM) Value Set Authority Center (VSAC), which resulted in the development of a framework specific to value set harmonization (NQF, 2016). However, as noted above, value set harmonization is but one facet of measure harmonization. Leveraging the meaningful work of the NQF, as well as themes addressed in the Blueprint, PCPI embarked
on a project to delve into other aspects of measure harmonization to help create a list of essential steps, thereby creating structure around a process that otherwise may seem confusing or rushed.

In November 2017, PCPI administered a member survey to obtain real-life harmonization experiences. The survey inquired about processes, successes and pain points (see Appendix C). We used those responses, as well as our experiences stewarding measures and working with other organizations to harmonize them, to develop the following methodology to guide organizations through this process.

Based on feedback from PCPI’s membership, there exists a need and demand to establish a methodology for harmonizing measures. This methodology will provide guidance on how to embark on these types of efforts amongst the broader measurement community, and address harmonizing measures across a variety of implementations and measure stewards. Creating a standardized approach will assist organizations engaging in these types of activities by providing a checklist of sorts, identifying key steps and considerations.

Measure Harmonization Steps

No two harmonization projects are identical, as each will have its own variables impacting the process and outcome. However, measure developers and stewards can still benefit from utilizing a standardized approach to each harmonization project. PCPI has developed a step-by-step guide to assist those embarking on harmonization efforts. While these steps have been broken up into different sections, it’s important to note that the sections and steps are not necessarily sequential, and some tasks may overlap sections. Harmonization projects often have steps occurring simultaneously, which may occur more often with a shortened timeframe to conduct the harmonization project.

The sections below contain detail about the various aspects to consider in your harmonization project. For convenience, the steps and individual tasks have been summarized into a manageable checklist, found in Table 1 on page 10 to help measure stewards and developers more easily navigate the process.

1. Overview of a harmonization project

Whether harmonization is prompted by an external source, such as CMS, another measure developer or public comment, or is internally initiated, there only needs to be one catalyst to launch this endeavor. With the rise in development or adaptation of measures for use in qualified clinical data registries (QCDRs), there has been a uptick in requests for harmonization. Usually there will be a reason and specific measure(s) brought to the forefront to ignite a harmonization project, but there may not be a clear selection of which measures will be included in the project.

Harmonization does not need to be limited to focusing on two or more measures that have already been fully developed. Rather, an organization may be beginning or partially through the initial development of a de novo measure and may identify a known existing, related measure(s) to compare to when making decisions during the measure development process.

When conducting a harmonization project, it is important to perform each of the following:

- Identify a measure(s) which may be considered a related or competing measure during an environmental scan
- Determine what resources (e.g., staffing, budget, time) are available to use throughout the harmonization project
• Contact measure developer(s) and any additional stakeholders who may contribute to the harmonization discussion
• Conduct an analysis of the measures’ specifications to highlight variation (e.g., denominator coding, definitions, data element inclusion)
• Identify the area(s) for potential harmonization based on variations
• Discuss the identified area(s) for potential harmonization; collaborate to ensure the measures are harmonized to the extent possible
• Determine final outcomes of harmonization; what changes will be made to a measure and how/when those changes will be made

Remember, related measures are either the same target population (denominator) with a different measure focus (numerator) or having the same measure focus but different target population. Competing measures have the same target population and measure focus which may suggest that the measures be consolidated into a single measure (one measure is maintained, while the other(s) are retired).

2. Convening a multi-stakeholder group
It is important to work directly with the measure steward and/or developer(s) of the measure(s) with whom you intend to harmonize. Additionally, it may prove beneficial to involve other stakeholders – beyond those originally involved in the measure development – to gain outside perspectives and provide a more robust review of the measures and differences. Other types of stakeholders to consider for participation in harmonization efforts include, but are not limited to:

• Electronic health record (EHR) vendors
• Federal agencies (e.g., national, state)
• Health IT organizations
• Individual clinicians from related areas of practice medicine
• Individual patients
• Medical or clinical specialty societies
• Patient advocacy groups
• Payers and health plans
• Pharmacological agencies
• Registry or vendors
• Terminology experts

Each of these types of participants can offer a unique perspective regarding the measures under consideration, and many of these stakeholder groups look for opportunities to participate in the measure development and maintenance process.

Once the appropriate stakeholders are identified, invite them to participate in your harmonization project. If this is an internally initiated project, providing background as to the catalyst for this effort will be important to open the channel of communication, and offer context to the stakeholder(s) for what the intended purpose and expected outcome(s) of this project will be. If this is a harmonization project spurred by the request of an external organization (e.g., CMS requests two QCDRs harmonize measures implemented in each), there will likely already exist context and a goal. Regardless, it is in the group’s best interest to reach out to the identified stakeholders as soon as possible to allow the greatest amount of time possible to the upcoming discussions and collaboration. This may also mean that other stakeholders may be identified as the harmonization work is underway.
It’s not essential to bring all of the aforementioned stakeholders to each harmonization project. The more people at the table, the more challenging the process may become, as there are more voices, concerns, and opinions weighing in. However, the goal of engaging a variety of stakeholders should be to obtain factual and usable information that will contribute to the discussion and decision of how to harmonize measures.

Based on existing networks, it may be necessary to work with other organizations and resources in order to ensure you reach the appropriate parties. When a measure steward is unsure about how to contact other measure stewards, the CMS Measures List, published each year, may prove valuable as it includes this information for all measures included in the federal programs. Additionally, PCPI has a large network of potentially relevant stakeholders, as listed above, and may be able to assist measure stewards in reaching out to initiate harmonization discussions. For measures which are undergoing NQF endorsement, the NQF can also help facilitate making connections among measure stewards.

3. Identifying areas for harmonization
It is important to fully understand which aspects of the measures may benefit from harmonization. Areas for harmonization may include, but are not limited to:

- Clinical focus (e.g., what aspect of care is being measured)
- Data source (e.g., administrative claims, electronic system)
- Care setting (e.g., ambulatory, inpatient)
- Level of analysis and/or attribution (e.g., clinician, facility, health plan)
- Data elements (e.g., diagnoses, laboratory tests)
- Value sets and/or coding (e.g., ICD-10-CM, LOINC®)
- Data capture (e.g., how data is captured, what system captures the data)

A harmonization project may focus on one specific area or could involve multiple areas that have been identified as having differences. Areas that may be appropriate to harmonize can be identified through comparison of language, clinical concepts, relationships among data elements (e.g., do two measures look at the same clinical action, but have different timings associated with them, or perhaps different results?), and coding. Upon completing the comparison of the measure specifications, any variation should be noted and reviewed. Certain differences may be appropriate to retain. For instance, a measure developer who focuses on the inpatient setting may have a measure with an outpatient counterpart. This variation is appropriate in the instance that the care settings are intentionally different. From this review and analysis, specific areas for harmonization should be able to be easily identified.

After review of the related measure(s), a measure steward should be able to classify which differences are appropriate to retain, given the initial development or recent discussions with clinical expert panels, and which might benefit stakeholders by harmonizing. Though the full, detailed specifications for externally stewarded measures may not be available at the time of initiating a harmonization project, once additional stakeholders are involved, it will be important to obtain the most current version of the measure, in its entirety, to conduct a more robust review, which may present additional areas for harmonization.

4. Collaborating
Collaboration can be one of the most challenging areas for measure development and maintenance but is also the most essential. This is also true of harmonization. Each of the stakeholders involved may have
a different governance structure and measure maintenance process, or parameters regarding how they contribute to the conversation.

Especially with new collaborations, it is important to level-set so all parties understand the purpose, process, and goal of the harmonization project. It may also be important to delineate roles for those involved, which may entail reaching out to external partners (e.g., clinical experts who were involved in the most recent measure maintenance), and possibly identifying who will serve as the lead communicator with the entity who initially requested the harmonization, which may or may not be one of the measure stewards involved in this process.

Below are a few steps to help organize and embark upon this collaborative process:

- Invite and convene all relevant stakeholders to the harmonization project. This entails ensuring the appropriate representatives are included early on, and are informed of the overall purpose (e.g., reduce burden for clinicians who use multiple registries which include similar measures with different coding) and goal (e.g., create a standardized definition/set of codes for clinical concepts in the measures) of the harmonization project.

- Share current measure documentation, including specifications, with all relevant stakeholders. Sharing the details of a measure early on allows all stakeholders to have a substantial amount of time to review, ask questions, and consider opportunities for harmonization. Without full measure details and/or specifications, the remaining process may prove difficult if the stakeholders are unwilling to share pertinent information that will help shape the harmonization considerations.

- Determine the expected length, process steps, and how the process will be managed. Establishing a timeline for each harmonization project is important, as it may impact the specifics surrounding the actual process (e.g., is there time for a public comment, outreach to additional subject matter experts). Additionally, the available timeline may shape the quantity or scope of changes which may be considered for the current harmonization effort. Outlining the process and figuring out how it will be managed may include noting if any parties may require approval of changes (e.g., a Board of Directors, measures committee, or Technical Expert Panel), determining lead points of contact for each stakeholder, and establishing which of the stakeholders will lead the process.

- Identify gaps in measures and areas for harmonization. This involves reviewing supporting evidence and guidelines, comparing measure specifications and development processes, and evaluating implementations of the measures. When initiating a harmonization project, the high-level areas (e.g., level of analysis, care setting, clinical action being assessed) for harmonization should be shared with all relevant stakeholders. However, once the project is underway, it may result in a deeper dive into the nuances of each measure (e.g., terminologies used to represent clinical data based on implementation, specific coding variations). A document, which will be used in further discussions, should be compiled to explicitly detail the identified variations.

- Discuss each individual organizations’ rationale for current specifications and review how an update to the measure may impact its use, implementation, and benchmarking. During this step, stakeholders can share their own priorities for the harmonization effort and share the details of the prior development and maintenance processes, to inform the group of how the
measure arrived at its current state. This is also an opportunity to highlight various use cases, guidelines or publications that may support a measure concept, or share prior considerations, obstacles, etc. which will provide useful background knowledge for those participating in the harmonization project. It’s during this time that the measure stewards and stakeholders can evaluate if there is enough evidence to support the existence of two or more separate measures, or if they might be combined into a single measure. Some points to consider during this step are how long the measures have been around, who was involved in the original development and/or most recent maintenance (e.g., were all relevant clinical specialties included), whether or not a measure is in use in federal programs, or even whether the measure has undergone a thorough vetting or review process for endorsement (e.g., the National Quality Forum).

- Prioritize resulting areas for harmonization and determine how the measures can be aligned in a meaningful way, without creating competing measures.

Upon review of the detailed measure narrative and specifications, any gaps or variance serves as a potential area for harmonization. The stakeholders should discuss the feasibility of any potential changes and prioritize those that can be implemented. This may result in a list of changes that can be made more immediately, and those that may be deferred for a variety of reasons, but which may be considered in a future harmonization process.

It may be helpful, as stakeholders convene to discuss the variation between measures, to solicit an unbiased, third party to facilitate the harmonization conversation. While this is not essential, this formality may aid the various parties in coming to mutual agreement on aspects of harmonization. The NQF, for example, will sometimes help facilitate harmonization discussions as a third party, helping to convene the appropriate parties for measures undergoing endorsement evaluation.

5. Finalizing your harmonization project

To close out your harmonization project, there should be a review of the points that have been considered via findings of areas of potential harmonization, as well as internal documentation of the rationale for why each of those areas was either updated or left alone.

- Determine if all potential areas for harmonization have been addressed. Denote what the outcome of the project’s harmonization effort was for each of the potential areas.
  This helps to make sure all the bases are covered, and individual items were not overlooked. It also allows all participants in the project to understand the individual item discussions and comments and can help shape any future collaborations or harmonization processes.

- Communicate the outcomes and agreed upon changes that will be made to the measure(s) with the initiator of the harmonization project, and any other stakeholders.
  If this was an internally initiated project, this may be communicated to an overseeing board or committee for each of the participating organizations. If this was an externally initiated project, this may require follow up with another organization or entity, including submission of responses in a public forum or to CMS, especially in instances where the harmonization request was a result of the QCDR measure nomination submission.

- Complete a close-out of this project.
  A project close-out can be a beneficial resource document to evaluate how effective the harmonization project was, detail certain obstacles or risks that might be mitigated in future projects and capture any final comments or concerns from all relevant stakeholders. This
document and information can be used in future projects to further develop project constraints or parameters. Additionally, if a measure(s) is undergoing NQF endorsement, producing a harmonization plan, documenting work completed to date and any future harmonization efforts, may prove beneficial during a Steering Committee review.

- Update measure documentation to reflect the changes. This may include updating information related to the processes employed during measure maintenance and documenting the rationale for making these changes. It may also entail incorporating changes, if determined appropriate, to the specifications for other data capture and/or reporting modalities (e.g., administrative claims, registry, EHR, etc.) in a timely manner so that a measure’s various specifications are aligned, to the extent possible. However, it should also be noted that changes to a measure’s specification may trigger additional testing needs.

Measure harmonization, as with maintenance, should be an iterative process; it should not be considered a “one size fits all” approach, nor a “one and done” process. By following an approach that can be easily implemented for each harmonization process, measure stewards can feel confident they have incorporated a more consistent and standardized methodology.
Table 1. Performance Measure Harmonization: A High-Level Step-by-Step Guide

| Overview of a harmonization project | • Identify related or competing measures during an environmental scan  
| • Determine resource availability  
| • Contact external stakeholders to participate in the discussion  
| • Conduct analysis of measure specifications  
| • Identify potential areas (variances) for harmonization  
| • Stakeholders work together to determine what will be harmonized  
| • Close out the project and update measures |

| Convening a multi-stakeholder group | • Electronic health record (EHR) vendors  
| • Federal agencies (e.g., national, state)  
| • Health IT organizations  
| • Individual clinicians from related areas of practice medicine  
| • Medical or clinical specialty societies  
| • Individual patients  
| • Patient advocacy groups  
| • Payers and health plans  
| • Pharmacological agencies  
| • Registry or vendors  
| • Terminology experts |

| Identifying areas for harmonization | • Clinical focus  
| • Data source  
| • Care setting  
| • Level of analysis / attribution  
| • Data elements  
| • Value sets and/or coding  
| • Data capture |

| Collaborating | • Invite and convene relevant stakeholders  
| • Share current documentation with all parties  
| • Determine expected length, process steps, and how process will be managed  
| • Discuss gaps in measurement and areas for harmonization  
| • Discuss rationale for current specifications  
| • Review how a measure update may impact its use, implementation, and benchmarking  
| • Prioritize resulting areas for harmonization |

| Finalizing your harmonization project | • Determine if all identified variations have been discussed  
| • Note outcomes of each topic of discussion  
| • Communicate outcomes and agreed upon changes with project initiator and stakeholders  
| • Complete a project close-out  
| • Update measure documentation to align with harmonization outcomes |
Other Considerations

Challenges in working with others
As previously noted, it can often be challenging to engage with external organizations who employ different measure development and maintenance processes. Part of this may result from a measure developer’s historical experience with maintenance of a particular measure; they may feel as though the measure has undergone a rigorous review by all necessary stakeholders. However, PCPI encourages all measure stewards, developers and stakeholders to be open to the harmonization process, especially as we move towards interoperability and the goal of being able to share patient data amongst all relevant care providers.

As previously stated, engaging a third-party facilitator or developing a governance structure to avoid any biases during harmonization efforts may alleviate tensions and help navigate difficult situations. Some measure stewards may be unwilling to modify their measures, and an unbiased individual or group may be a solution to overcoming some of these challenges.

Timeframe for updating measures
Via the PCPI member survey, we heard that several harmonization projects were considered unsuccessful due to other developers’ unwillingness to modify measures in an “off cycle.” We understand this to mean that measure developers may have a pre-designated measure maintenance cycle, whether it’s related to a federal program or simply to internal deadlines, and they do not wish to alter the timeframe in which that occurs. However, based on PCPI’s experience with measure maintenance and harmonization, important updates to measures may be missed because of timelines.

PCPI cautions measure stewards and developers regarding letting reporting programs, submission for endorsement (e.g., NQF measure projects), or even internal plans or deadlines dictate their willingness to engage in meaningful discussion about potential future updates. As many have experienced, measure development and maintenance projects usually do not have a quick turnaround, as these can often take months or upwards of a year to complete. Though there have been measure development and harmonization projects which have been condensed into a matter of a month or so, depending on the complexity of the measure(s), it may be best to plan for a longer turnaround time.

When it comes to collaboration, especially across different organization and stakeholders, this work may require many discussions over a longer period of time. It is best to begin conversations as soon as a potential update or harmonization issue presents itself, to allow for a research, robust discussion, and fully informed decision making. If that conversation results in changes to a measure, when that can be implemented may be determined by various factors, especially if used in a federal reporting program such as the Quality Payment Program whose annual update cycle may impact the timing, but at least the resulting change has been thoroughly vetted and will be expected to be put into effect. Additionally, related to federal programs, CMS has encouraged measure developers to share planned updates to measures within the federal programs, especially those considered substantive in nature, as early as possible.

Substantiating evidence to support measures
In some instances, we received feedback that there were challenges with finding supporting evidence or guidelines for changes to measures. While there may be “standards of care” that exist based on consensus, there is also a strong emphasis within the measure development community on creating measures based on solid evidence, especially if a wide array of clinicians or facilities would be subject to
use of that measure. Therefore, it is important that a thorough literature review be completed, and all relevant stakeholders be involved throughout the measure development or maintenance process. By fostering this collaboration early on, it may incite a need for additional study or updates to published guidelines that may eventually support the sought-after measure concept.

Another evidence related consideration is that there may be existing evidence, guidelines, and studies which support the variations across measures. In instances where support exists for the individual measures, including when supporting literature does not include aligned recommendations, harmonization may not be warranted on account of there being a strong rationale for why each of the measures is constructed in such a manner. However, if it is determined that the evidence for a measure has changed or was not strong to begin with – or even if it was consensus-based, that may indicate a measure may be ready to be retired so that the supported measure remains.

Conclusion

Measure harmonization is imperative to improving the ability of those who report clinical performance measures based on the idea that there are consistent approaches to measure requirements and definitions. Shared information among the various entities impacted by similar measures helps to establish meaningful relationships and a theme of working towards the betterment of medicine, and interoperability.

We encourage those who carry out harmonization projects, and implement this methodology, to share their experiences with us, so that PCPI can continue to refine and improve upon this methodology. Any comments or feedback can be sent to PCPImeasures@thepcpi.org.
Appendix A

Glossary of Terms

**Attribution:** In the context of performance measures, attribution generally refers to who is held accountable for the clinical actions being assessed by the measure numerator, or measure focus.

**Clinical Quality Language (CQL):** Clinical Quality Language (CQL) is a Health Level Seven International (HL7) authoring language standard that provides the ability to express logic that is human readable yet structured enough for processing a query electronically. CQL is used in Health Quality Measure Format (HQMF) as part of eCQM measure packages and will be used beginning in 2019 implementation year for eCQMs included in the Quality Payment Program.

**Competing measures:** Performance measures that have the same measure focus and target population.

**Data elements:** The foundation of quality measure specifications, data elements are unique clinical concepts that are used within the measure specifications to satisfy various measure requirements and conditions.

**Harmonization:** The process of aligning or standardizing specifications of related measures so that they are uniform or compatible, unless differences are justified.

**Level of analysis:** Measures can be designed for implementation at specific levels, meaning that the measure is assessed at a specific level. The various levels of analysis may be at the care provider (clinician) level, facility or practice level, or even at higher levels such as statewide or health plan.

**Measure focus:** For the purposes of measurement, the measure focus refers to the measure numerator, or the clinical action being assessed by the measure. Examples of measure focus include screening a patient for tobacco use, prescribing a specific medication, or conducting blood tests.

**National Quality Forum (NQF):** The National Quality Forum (NQF) is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare. More information can be found at [http://www.qualityforum.org](http://www.qualityforum.org).

**Related measures:** Performance measures that have either the same target population with a different measure focus, or the same measure focus but different target population.

**Target population:** For the purposes of measurement, the target population refers to the measure denominator, where in order to be included in the measure, specific criteria must be met. Examples of denominator criterion include patients with specific diagnoses, care settings or encounter requirements, and age demographics.
Appendix B

Harmonization in Action: A Fictitious Illustration of the Harmonization Steps

The Performance Measure Association (PMA) is newer to the measure development game and recently developed many measures that were submitted as part of their QCDR self-nomination for the 2018 performance year. They recently received feedback from CMS on the measures they submitted for inclusion, and one of the items of feedback was that a measure similar to theirs was submitted by another QCDR, and CMS requested that the two organizations harmonize their measures because they are assessing the same clinical focus area (i.e., numerator), and they gave a month’s time to sort this out before circling back. PMA learned that the other measure was stewarded by the Quality Measures Association (QMA), which meant that they would need to figure out a way to collaborate with QMA on harmonizing the two measures.

With the timeframe set at a month and a related measure already identified, PMA got started on the harmonization process steps, and set out to contact QMA. Since PMA didn’t have many existing relationships with other measure developers, the staff did not know who to reach out to at QMA. PMA visited the QMA website and filled out the contact form, in the hopes a response would point them in the right direction. A few days later, QMA quality measure staff member who maintains their measures followed up to the request. The two organizations arranged for an introductory call, during which the teams explained their measure development process. The two groups felt it would be important to have clinician input, so each designated two clinical experts to participate in the harmonization discussions.

The following week, the PMA and QMA shared the measure specifications, as they were intended to be implemented in the 2018 QCDR. PMA staff conducted a thorough review, comparing the two measures, paying close attention to the coding and measure definitions. PMA discovered that the greatest variances were within the specific drug lists for one of the medications included in the measure, and the data source. It appeared that the PMA measure included many more drugs in the list required to meet the measure numerator, and that PMA expected the data to come from an electronic data source (eg, EHR), whereas QMA’s measure was primarily coming from claims information.

During the next call between the organizations, which occurred about two weeks, or halfway, into the harmonization project, PMA and QMA addressed the variances they found. The clinical expert for QMA was insistent on the drug list included in their measure, which was not as all-encompassing as PMA’s list. Through the conversation, it was determined that QMA had adopted a more stringent approach to incorporating drugs in the measure based on their efficacy. PMA staff and their clinical experts considered this rationale, while also sharing that they chose to not be as prescriptive based on the evidence but included an entire class of drugs. Upon further consideration, PMA decided to align their measure’s drug list with that used in the QMA measure, but insisted they wanted to run this decision by their full quality measure technical expert panel (TEP). The group also discussed the discrepancy in data sources but determined that this variance was okay to leave unaddressed, which also meant that there would be differences in how certain aspects of the measure are captured and/or documented.

PMA alerted their quality measure TEP to the proposed revision to the measure and sought the TEP’s vote. Upon receiving a majority decision to move forward with the proposed change, PMA followed up with QMA to let them know the final decision and incorporated this into their measure language and specification. PMA and QMA wrote a summary of the harmonization process and outcomes, and sent an
email to CMS, while also retaining a copy for their future work, as it will be important to remember the rationale behind the change, and also keep in contact with QMA for future measure maintenance work.
Appendix C

PCPI’s Measure Harmonization Project
Measure Steward Harmonization Experience Survey

Based on PCPI’s involvement in various harmonization requests and efforts, as well as information presented by some of our member organizations on this topic, the PCPI’s Measures Advisory Committee (MAC) has identified and prioritized a project to develop a harmonization framework or methodology. In order to accomplish this, we seek input on what you’ve experienced in your harmonization efforts, regardless of source or size. PCPI is very interested to learn what processes and practices organizations have employed, as well as what successes or failures may have resulted from these efforts. This information will help us build a stronger set of recommendations and steps to help standardize this process, and guide those who embark on harmonization efforts.

We welcome multiple harmonization project examples from an individual organization and ask that you submit information regarding each project or effort individually, via this survey.

We thank you, in advance, for your valuable input and time sharing your first-hand experiences with us.

1. Organization Name

2. What was the focus of this harmonization project? (Select all that apply.)
   - Value sets and/or coding
   - Data elements
   - Care setting
   - Clinical focus
   - Level of analysis
   - Other (please specify) _________

3. Source of harmonization
   - CMS request
   - Outreach from external organization (other than CMS)
   - Internally initiated
   - Other (please specify) _________

4. How many other organizations, excluding your own, were involved in this project?

5. What type of organization(s) was involved? (Select all that apply.)
   - Federal
   - Specialty society
   - Patient advocacy organization
   - Other (please specify) _________

6. If you would like to list the organization(s) involved in your harmonization project, please do so below.

7. How many measures were involved in this project?
8. How long, in months, did this project take from start to completion?

9. Overall, would you say this was a successful harmonization effort?
   o Yes
   o No

10. Please provide rationale for why you considered this effort a success or not.

11. Please outline the steps and/or tasks undertaken from the start of this harmonization project through its completion.

12. Did you employ a particular governance structure?
    o No
    o Yes (please describe)

13. Describe any challenges you encountered during this project.

14. Describe any successes which resulted from this project.

15. Do you have another harmonization project you’d like to share? (If you select ‘Yes’, you will be asked to complete the same series of questions for the subsequent project.)
   o Yes
   o No
Appendix D

References


3. CMS created the “Blueprint for the CMS Measures Management System” to document the core set of business processes and decision-making criteria for measure development. It is a helpful resource for stakeholders interested in developing measure or understanding the measure development process. Link to CMS Blueprint: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html.

4. The Quality Data Model (QDM) is an information model that defines relationships between patients and clinical concepts in a standardized format to enable electronic quality performance measurement. The model is the current structure for electronically representing quality measure concepts. Link to Quality Data Model: https://ecqi.healthit.gov/qdm-quality-data-model.

5. Clinical Quality Language (CQL) is a Health Level Seven International (HL7) authoring language standard that provides the ability to express logic that is human readable yet structured enough for processing a query electronically. Information regarding CQL is available through the eCQI Resource Center, which links directly to the most up to date HL7 specification version. Link to Clinical Quality Language: https://ecqi.healthit.gov/cql-clinical-quality-language.


7. The NQF reviewed its guidance on evaluating evidence and measure testing and proposed modifications to address major challenges. Link to the final report: https://www.qualityforum.org/Projects/i-m/Measure_Evaluation_Guidance/Measure_Evaluation_Guidance.aspx#t=1&s=&p=. 