**Guiding Principles for eCQM Development**

1. **Eliminate Retooling:** Retooling legacy paper abstracted or claims based measures will not be the default. We will reengineer to meet our goals based on the principles below.
2. **Eliminate Defects:** In early planning for Stage 3, we described a goal to “make better measures, instead of making more measures”; a significant portion of measure development, in advance of the Stage 3 release, will be devoted to review and repair of the 2014 eCQM measure set.
3. **Build measures to multidimensional criteria**. To the goal of making “better” measures, e-measures should be evidence-based, use common data elements from HHS-validated standard terminologies, use standardized value sets, and execute unambiguous logic. Through rigorous testing measure should be demonstrated to be feasible, linked by high-quality evidence to important patient outcomes, possess both scientific reliability and validity to measurement community and face validity with clinicians and the public
4. **Test extensively before release.** Each e-measure specification should be tested for data element capture, score calculation, and QRDA submission in multiple EHRs before incorporation into HHS programs.
5. **Build valuable measures.** The cost of making the measures will be commensurate with the value achieved from the measurement. The cost of making the measures can be minimized by aligning measures with MU Functional Objectives, aligning components across eCQMs, making the cost more visible to measure developers and policy makers, minimizing exclusions and exceptions and appropriately resetting measure targets.
6. **Update frequently**: Consistent HIT-based measurement requires unambiguous specification and frequently publicized corrections to eCQM specification defects.
7. **Democratize Development**: To keep Meaningful Use relevant to our providers and patients, we will broaden the scope of measure development contributors. This will require an integrated open source e-measure development toolkit that includes a searchable library of e-measure components, guides construction of logic, editing of value sets, verification codes, creation of test decks and simulation calculations.
8. **Align eCQM Programs**: We will continue to minimize provider and vendor burden by maintaining a core set of eCQMs that can be measured and reported for multiple programs.
9. **Harmonize eCQMs with CDS.** We willalign eCQM technically and clinically for CDS to support the HIT enabled HIT toolkit.

DL: Be careful with alignment to simplicity…also want to emphasize that this document and it keeps living in the future, we should think about what we mean by the word “better” and we should think about what we mean by the word “value,” in number 4, and valuable.

-- We don’t want to align at the expense of delivering value to a variety of programs with a variety of interests.

SK: Update frequently…and test frequently

TC: Can we both balance the tension between democratized development and defect reduction?

 - Clarify the harmonization of CQMs and CDS be broader than reminders?

 -What would the software development toolkit look like?

HB: validity to patients and clinicians is more important and should be a higher bar

--maybe a “defect” free process