

Technical Expert Panel Nomination Form

Project Title: Development, Reevaluation, and Implementation of Outpatient Outcome and Efficiency Measures

Note to Applicant/Nominee: Please read the Technical Expert Panel (TEP) charter for more information about the project and TEP participant requirements. Please attach additional pages if necessary.

Instructions:

Applicants/nominees must submit these documents **with this completed and signed form**:

1. A letter of interest (not to exceed 2 pages) highlighting experience/knowledge relevant to the TEP objectives and involvement in measure development.
 - Consumer/patient/family (caregiver) applicants/nominees are not expected to have experience in measure development. These applicants can describe their interest in the topic.
2. A curriculum vitae (CV) or a summary of relevant experience (including publications) for a maximum of 10 pages.
 - Consumer/patient/family (caregiver) applicants/nominees are not required to submit a CV.

Send this completed and signed TEP Nomination Form, letter of interest, and CV to Lewin with "Nomination" in the subject line to Imaging.Measures@Lewin.com. The documents are due by close of business on January 15, Eastern Time.

Applicant/Nominee Information (Self-nominations are acceptable):

Name and credentials, if any (degrees, certifications, etc.)

For patient/family (caregiver) participants only: I wish to keep my name confidential. Yes No

Professional role or title (patient, family, caregiver, physician, measure developer, etc.):

Organizational affiliation: (Employer or organization you represent, if any.)

Applicant's preferred mailing address (may be business or residential):

Street:

City/State/Zip

Telephone:

Email:

Person Recommending the Nominee:

Complete this section only if you are nominating a third party for the TEP. You must sign this form and attest that you have notified the nominee of this action and they are agreeable to serving on the TEP.

Name and credentials, if any (degrees, certifications, etc.)

For patient/family (caregiver) participants only: I wish to keep my name confidential. Yes No

Professional role or title: (patient, family, caregiver, physician, measure developer, etc.)

Organizational affiliation, if any: (Employer or organization you represent.)

Nominator's preferred mailing address (business or residential):

Street:

City/State/Zip:

Telephone:

Email:

I attest that I have notified the nominee of this action and that the nominee is agreeable to serve on the TEP.

Signature:

Date:

The nominee must submit the remainder of the nomination package within the specified period for consideration.

Name and credentials, if any (degrees, certifications, etc.)

For patient/family (caregiver) participants only: I wish to keep my name confidential. Yes No

Professional role or title: (patient, family, caregiver, physician, measure developer, etc.)

Organizational affiliation, if any: (Employer or organization you represent.)

Nominator's preferred mailing address (business or residential):

Street:

City/State/Zip:

Telephone:

Email:

Applicant/Nominee's Disclosure:

1. Do you or any family members have a financial interest, arrangement, or affiliation with any corporate organizations that may create a potential conflict of interest? Yes No

If yes, describe (for example, grant/research support, consultant, speaker's bureau, major stock shareholder, or other financial or material support). Include the name of the corporation/organization).

2. Do you or any family members have intellectual interest in a study or other research related to the quality measures under consideration? Yes No

If yes, describe the type of intellectual interest and the name of the organization/group:

Applicant/Nominee's Participation on the TEP (select all that apply):

- The applicant will serve in the capacity of a clinical or methodological expert.
- The applicant will serve in the capacity of a patient.
- The applicant will serve in the capacity of a family member or caregiver of a patient.

Applicant/Nominee's Area(s) of Expertise or Perspective(s) (select all that apply):

- Consumers, patients, family members, and caregivers
- Consumer advocates
- Clinicians
- Informaticists, epidemiologists, methodologists, and other experts in measurement science
- Health system and hospital representatives
- Payers
- Healthcare purchasers
- Healthcare disparities experts
- Other (specify):

Name and credentials, if any (degrees, certifications, etc.)

For patient/family (caregiver) participants only: I wish to keep my name confidential. Yes No

Professional role or title: (patient, family, caregiver, physician, measure developer, etc.)

Organizational affiliation, if any: (Employer or organization you represent.)

Nominator's preferred mailing address (business or residential):

Street:

City/State/Zip:

Telephone:

Email:

Applicant/Nominee's Professional Category (select all that apply):

- primary care/general practitioner/internist
- physician specialist (specify):
- non-physician clinician (specify):
- other (specify):
- not applicable

Applicant/Nominee's Health Care Setting Experience (select all that apply):

- individual or small group practice
- large group practice
- accountable care organization
- managed care
- hospital- or facility-based practice
- palliative care/hospice
- rural practice
- other (specify):
- not applicable

Applicant/Nominee's Agreement:

- If my conflict of interest status changes at any time during my service as a member of this TEP, I will notify CORE and Lewin.
- It is anticipated that there will be up to three meetings per year via teleconference. I am able to commit to attending TEP meetings in person, by teleconference, or by mutually agreed-upon alternative means.
- If selected to participate in the TEP, and the measures are submitted to a measure endorsement organization, such as the National Quality Forum (NQF), I will be available to discuss the measures with the organization or its representatives and work with the measure developer to make revisions to the measures, if necessary.
- If selected to participate in the TEP, I will keep all materials and discussions confidential, including not sharing within my organization, until such time that CMS authorizes their release.

Name and credentials, if any (degrees, certifications, etc.)

For patient/family (caregiver) participants only: I wish to keep my name confidential. Yes No

Professional role or title: (patient, family, caregiver, physician, measure developer, etc.)

Organizational affiliation, if any: (Employer or organization you represent.)

Nominator's preferred mailing address (business or residential):

Street:

City/State/Zip:

Telephone:

Email:

- I understand that participation is voluntary and that my input will be recorded in the meeting minutes.
- I understand that proceedings of the TEP will be summarized in a report that may be disclosed to the public.
- I have read the TEP Charter for information on participation, conflicts of interest, and financial disclosure.

I have read the above and agree to abide by it.

Signature:

Date:

Additional Comments: