DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretarial Review and Publication of the Annual Report to Congress Submitted by the Contracted Consensus-Based Entity Regarding Performance Measurement

AGENCY: Office of the Secretary of Health and Human Services, HHS.

ACTION: Notice.

SUMMARY: This notice acknowledges the Secretary of the Department of Health and Human Services' (HHS) receipt and review of the annual report submitted to the Secretary and Congress by the contracted consensus-based entity as mandated by section 1890(b)(5) of the Social Security Act, as added by section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The statute requires the Secretary to publish the report in the **Federal Register** together with any comments of the Secretary on the report not later than six months after receiving the report. This notice fulfills those requirements.

FOR FURTHER INFORMATION CONTACT: Kate Goodrich (202) 690–7213.

I. Background

Rising health care costs coupled with the growing concern over the level and variation in quality and efficiency in the provision of health care raise important challenges for the United States. Section 183 of MIPPA also required the Secretary of the Department of Health and Human Services (HHS) to contract with a consensus-based entity to perform various duties with respect to health care performance measurement. These activities support HHS's efforts to achieve value as a purchaser of high-quality, patient-centered, and financially sustainable health care. The statute mandates that the contract be competitively awarded for a period of four years and may be renewed under a subsequent competitive contracting process.

In January, 2009, a competitive contract was awarded by HHS to the National Quality Forum (NQF) for a four-year period. The contract specified that NQF should conduct its business in an open and transparent manner, provide the opportunity for public comment and ensure that membership fees do not pose a barrier to participation in the scope of HHS's contract activities, if applicable.

The HHS four-year contract with NQF includes the following major tasks:

Formulation of a National Strategy and Priorities for Health Care Performance—NQF shall synthesize evidence and convene key stakeholders on the formulation of an integrated national strategy and priorities for health care performance measurement in all applicable settings. NQF shall give priority to measures that: address the health care provided to patients with prevalent, high-cost chronic diseases; provide the greatest potential for improving quality, efficiency and patient-centered health care and may be implemented rapidly due to existing evidence, standards of care or other reasons. NQF shall consider measures that assist consumers and patients in making informed health care decision; address health disparities across groups and areas; and address the continuum of care across multiple providers, practitioners and settings.

Implementation of a Consensus Process for Endorsement of Health Care Quality Measures—NQF shall implement a consensus process for endorsement of standardized health care performance measures which shall consider whether measures are evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics such as health status, language capabilities, race or ethnicity, and income level and is consistent across types of providers including hospitals and physicians.

Maintenance of Consensus Endorsed Measures—NQF shall establish and implement a maintenance process to ensure that endorsed measures are updated (or retired if obsolete) as new evidence is developed.

Promotion of Electronic Health Records—NQF shall promote the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information.

Focused Measure Development, Harmonization and Endorsement Efforts To Fill Critical Gaps in Performance Measurement—NQF shall complete targeted tasks to support performance measurement development, harmonization, endorsement and/or gap analysis.

Development of a Public Web Site for Project Documents—NQF shall develop a public Web site to provide access to project documents and processes. The HHS contract work is found at: *http://www.qualityforum.org/projects/ongoing/hhs/.*

Annual Report to Congress and the Secretary—Under section 1890(b)(5)(A) of the Act, by not later than March 1 of each year (beginning with 2009), NQF shall submit to Congress and the Secretary of HHS an annual report. The report shall contain a description of the implementation of quality measurement initiatives under the Act and the coordination of such initiatives with quality initiatives implemented by other payers; a summary of activities and recommendations from the national strategy and priorities for health care performance measurement tasks; and a discussion of performance by NQF of the duties required under the HHS contract. Section 1890(b)(5)(B) of the Social Security Act requires the Secretarial review of the annual report to Congress upon receipt and the publication of the report in the **Federal Register** together with any Secretarial comments not later than 6 months after receiving the report.

The first annual report covered the performance period of January 14, 2009 to February 28, 2009 or the first six weeks post contract award. Given the short timeframe between award and the statutory requirement for the submission of the first annual report, this first report provided a brief summary of future plans. In March 2009, NQF submitted the first annual report to Congress and the Secretary of HHS. The Secretary published a notice in the **Federal Register** in compliance with the statutory mandate for review and publication of the annual report on September 10, 2009 (74 FR 46594).

In March 2010, NQF submitted to Congress and the Secretary the second annual report covering the period of performance of March 1, 2009 through February 28, 2010. The second annual report was published in the **Federal Register** on October 22, 2010 (75 FR 65340) to comply with the statutorily required Secretarial review and publication.

In March 2011, NQF submitted the third annual report to Congress and the Secretary of HHS. This notice complies with the statutory requirement for Secretarial review and publication of the third annual report covering the period of performance of March 1, 2010 through February 28, 2011.

The Patient Protection and Affordable Care Act of 2010 (ACA) was signed into law on March 23, 2011. Section 3014 of this Act included a time-sensitive requirement for NQF to provide input into the national priorities for consideration under for the National Strategy for Quality for Improvement in Healthcare. As a result, one additional activity was added to the contract to fulfill this requirement within the contract year. The NQF convened the National Priorities Partnership and

developed a consensus report on input to HHS on the development of the National Quality Strategy.

II. March 2011—NQF Report to Congress and the HHS Secretary

Submitted in March 2011, the third annual report to Congress and the Secretary spans the period of January 14, 2010 through January 13, 2011.

A copy of NQF's submission of the March 2011 annual report to Congress and the Secretary of HHS can be found at: *http://www.qualityforum.org/projects/hhs/.*

The 2011 NQF annual report is reproduced in section III of this notice.

III. NQF March 2011 Annual Report

Advancing Performance Measurement: NQF Report to Congress 2011

Report to the Congress and the Secretary of the U.S. Department of Health and Human Services, Covering the Period of January 14, 2010, to January 13, 2011 Pursuant to PL 110–275 and Contract #HHSM–500–2009–00010C

NQF Mission

The National Quality Forum (NQF) operates under a three-part mission to improve the quality of American healthcare by:

- Building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.

As a private-sector standard-setting body recognized under the National Technology Transfer and Advancement Act (Pub. L. 104–113), NQF endorses standardized performance measures, serious reportable events, and safe practices. NQF also serves as the convener of two multi-stakeholder partnerships: the National Priorities Partnership, which provides guidance on setting national priorities, goals, and strategic improvement opportunities; and the Measure Applications Partnership, which recommends measures for use in various public reporting, payment, and other programs.

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Foreword

In 2008, Congress passed the Medicare Improvements for Patients and Providers Act (Pub. L. 110–275),[1] signifying its growing recognition of the systemic nature of the nation's healthcare quality issues. The Act set bearings for the national healthcare performance improvement movement and charted a course for national action, presenting the opportunity to unify the nation's disparate healthcare quality improvement efforts into a coherent national strategy. Importantly, it did not impose top-down direction to achieve its goals. Instead, the Act provides guidance and resources for the federal government to work with a consensus-based entity to identify priorities and performance measures through an open and transparent decision-making process that affords an opportunity for all stakeholders to participate.

On January 14, 2009, the National Quality Forum (NQF) was awarded a contract that addresses the Act's Section 183, which calls for the Department of Health and Human Services (HHS) ''to contract with a consensus-based entity, such as the National Quality Forum,'' to achieve many of these quality improvement goals. This contract subsequently was modified to accommodate specific work called for under the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148).[2] This report summarizes the work performed under this contract between January 14, 2010, and January 13, 2011, the second full year that the HHS contract has been in place.

The first year of the contract was devoted to building infrastructure to support healthcare quality. We are pleased to report that in the second year of the contract, NQF has leveraged that infrastructure to demonstrate real achievements in the areas of the identification of priorities and gaps in available performance measures; adaptation of more than 100 measures for use in electronic health records; and endorsement of 62 new measures. These are concrete, measurable, and sustainable accomplishments in the nation's quality infrastructure that will translate into more effective performance improvement, public reporting, and value-based payment programs. We are grateful to the Congress and HHS for their continued support of NQF and, more broadly, of the quality enterprise in the United States. Their commitment to healthcare quality improvement is thoughtful, clear, and unquestioned. We also thank the more than 430 institutional members of NQF, the hundreds of experts who volunteer to participate in NQF expert panels, and NQF staff, whose efforts have contributed to a healthcare system that is becoming, as the Institute of Medicine (IOM) envisioned in its ''call to action'' a decade ago, safe, effective, patient-centered, timely, efficient, and equitable.

William L. Roper,

Chair, Board of Directors, National Quality Forum.

Janet M. Corrigan,

President and Chief Executive Officer, National Quality Forum.

Notes

1. U.S. Congress, Medicare Improvements for Patients and Providers Act (Pub. L. 110–275), Washington, DC: U.S. Government Printing Office: 2008. Available at *http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_public_laws&docid=f:publ275.110.pdf.* Last accessed December 2010.

2. U.S. Congress, Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), Washington, DC: U.S. Government Printing Office; 2010. Available at *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.* Last accessed December 2010.

I. Executive Summary

Key strategies for reforming healthcare include: Publicly reporting performance results to support informed consumer decision-making; aligning payments with value; rewarding providers for investing in health information technology (health IT) and using it to improve patient care; and providing knowledge and tools to healthcare providers and professionals to help them improve their performance. Foundational to the success of all of these efforts is a robust ''quality measurement enterprise'' that includes priorities and goals for improvement; standardized performance measures; an electronic data platform that supports measurement and improvement; use of measures in payment, public reporting, health IT investment programs, and other areas; and performance improvement initiatives in all healthcare settings. Many public- and private-sector organizations have important responsibilities in the quality

measurement enterprise, such as various federal agencies, public and private purchasers, measure developers, the National Quality Forum (NQF), accreditation and certification entities, various quality alliances at the national and community levels, state governments, and others.

Recognizing the widespread and systemic nature of the nation's healthcare quality and cost challenges and the need to build the nation's quality measurement enterprise, Congress passed the Medicare Improvements for Patients and Providers Act (Pub. L. 110–275) in 2008. On January 14, 2009, NQF was awarded a contract that addresses the Act's Section 183, which calls for the Department of Health and Human Services (HHS) ''to contract with a consensus-based entity, such as the National Quality Forum,'' to carry out work related to its quality improvement goals. On September 20, 2010, this contract was modified to accommodate specific work called for under the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148).[1] This report summarizes the work performed under this contract between January 14, 2010, and January 13, 2011. Appendix C provides a list of the reports produced.

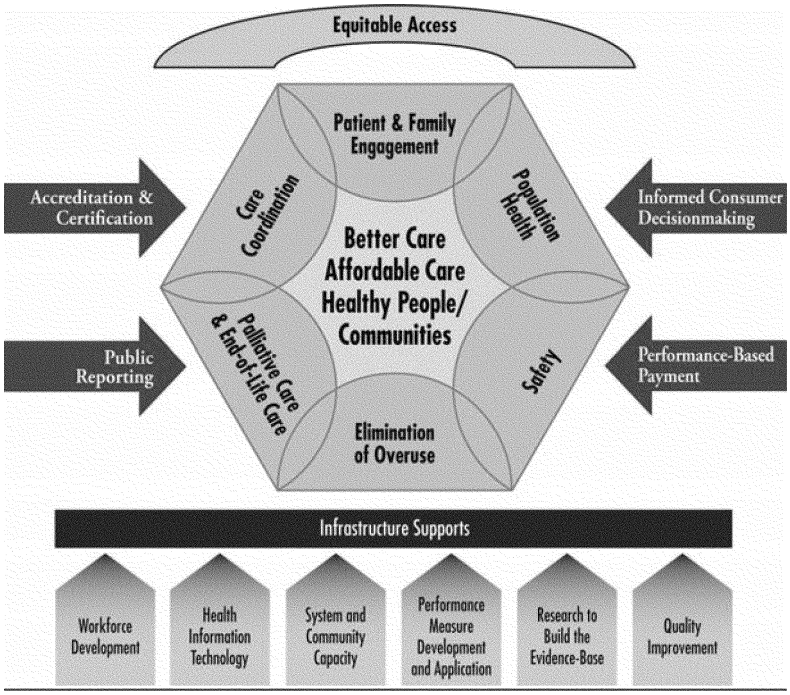
During the contract period, NQF made important contributions to the following quality enterprise functions: setting priorities and goals, endorsing performance measures, building an infrastructure to support performance measurement using an electronic data platform, and providing input to the selection of measures for determining ''meaningful use'' of health IT.

National Priorities

Setting national priorities is a critical first step to addressing our country's serious safety, quality, and cost challenges. Providers cannot measure and improve in all areas at once. Priorities focus attention on those areas most likely to produce the greatest return on investment in terms of better health and healthcare. National priorities, especially when established with input from multiple stakeholders, also serve as a starting point for alignment of public- and private-sector efforts to improve performance. In 2010, NQF made three contributions to national priority-setting initiatives: providing guidance to HHS on the proposed National Health Care Quality Strategy, identifying a prioritized list of high-impact conditions for Medicare beneficiaries, and specifying an agenda for measure development and endorsement to fill gaps in available measures.

The Affordable Care Act calls for HHS to establish a National Health Care Quality Strategy and to consult with a consensus-based entity to convene a multi-stakeholder group to provide input on national priorities for improvement in population health and the delivery of healthcare services. When asked to perform this role, NQF convened the National Priorities Partnership (NPP), a collaborative that now includes 48 leading organizations. In October 2010, NPP submitted its report to HHS, recommending eight priority areas for national action. These include the original six priorities NPP identified in a priority-setting effort in 2008: (1) Patient and family engagement, (2) population health, (3) safety, (4) care coordination, (5) palliative and end-of-life care, and (6) overuse. They also include the addition of two areas of focus: (1) Equitable access to ensure that all patients have access to affordable, timely, and high-quality care; and (2) infrastructure supports (*e.g.,* health IT) to address underlying system changes that will be necessary to attain the goals of the other priority areas. NPP also offered aspirational and actionable goals to be achieved over the next three to five years for each priority area.

Recommendations of the National Priorities Partnership



Source: National Quality Forum (NQF), *Input to the Secretary of Health and Human Services on Priorities for the 2011 National Quality Strategy,* Washington, DC: NQF; 2010. Available at *http://www.nationalprioritiespartnership.org/.* Last accessed February 2011.

Complementing NPP's work, which focused on ''cross-cutting'' areas (*e.g.,* care coordination) that affect all or most patients, was the work of NQF's Measure Prioritization Advisory Committee, which prioritized the top 20 high-impact Medicare conditions that account for more than 90 percent of Medicare costs. Improvements in the safety and effectiveness of the care processes for these conditions can affect the outcomes of millions of Americans and eliminate waste from the health system.

*Prioritized List of 20 High-Impact Medicare Conditions**

(1) Major depression
(2) Congestive heart failure
(3) Ischemic heart disease
(4) Diabetes
(5) Stroke/transient ischemic attack
(6) Alzheimer's disease
(7) Breast cancer
(8) Chronic obstructive pulmonary disease
(9) Acute myocardial infarction
(10) Colorectal cancer
(11) Hip/pelvic fracture
(12) Chronic renal disease
(13) Prostate cancer
(14) Rheumatoid arthritis/osteoarthritis
(15) Atrial fibrillation
(16) Lung cancer
(17) Cataract
(18) Osteoporosis
(19) Glaucoma
(20) Endometrial cancer

*As determined by NQF Measure Prioritization Advisory Committee under contract to HHS.

Source: NQF, *Prioritization of High-Impact Medicare Conditions and Measure Gaps,* Washington, DC: NQF; 2010. Available at *http://www.qualityforum.org/projects/prioritization.aspx#t=2&s=&p=4%7C.* Last accessed February 2011.

Taken together, cross-cutting areas and the prioritized conditions provide a two-dimensional framework for performance measurement. The current portfolio of NQF-endorsed measures includes many measures applicable to these cross-cutting areas and leading conditions, but there are important gaps. To advise HHS on how best to focus measure development resources on filling these gaps, NQF was asked to construct an agenda for measure development and endorsement. In constructing this agenda, the NQF Measure Prioritization Advisory Committee also considered child health measurement needs and the needs of the broader population health community. The final report, *Measure Development and Endorsement Agenda* (January 2011, available at *http://www.qualityforum.org/MeasureDevelopmentandEndorsementAgenda.aspx*), provides prioritized lists of measure gaps in eight areas: (1) Resource use/overuse, (2) care coordination and management, (3) health status, (4) safety processes and outcomes, (5) patient and family engagement, (6) system infrastructure supports, (7) population health, and (8) palliative care. As described below, efforts are well underway to fill these gaps.

Performance Measures

The NQF portfolio of endorsed measures includes more than 625 measures that support the needs of both public- and private-sector stakeholders and are appropriate for use in accountability and quality improvement programs. The measures fall into the following major categories: Measures of patient outcomes (*e.g.,* mortality, readmissions, complications, health functioning); care processes (measures of adherence to practice guidelines, such as prescribing beta antagonists after heart attacks); patient experience (*e.g.,* patient's perception of the quality of hospital care); resource use measures (*e.g.,* average nursing care hours per patient day); and composite measures (*e.g.,* overall indicator of pediatric patient safety constructed from measures of adverse events). Although the total number of measures is sizable, the number applicable to a given provider type—ambulatory practices, emergency services, hospitals, nursing homes, home health, rehabilitation services, mental health and substance abuse providers, kidney dialysis centers, and health plans—is more limited. To meet the needs of many, the portfolio also must accommodate measures that run off different data platforms (*e.g.,* paper records, administrative/claims data, electronic health records) during this period of transition to an electronic platform.

During the contract period, the HHS contract provided support for measure endorsement projects in the following areas: Patient outcomes for the 20 high-impact Medicare conditions; patient safety, including medication safety and healthcare-associated infections; nursing homes; child health; and efficiency and resource use. NQF's endorsement process, which includes evaluation by technical experts and a multi-stakeholder panel, as well as extensive public input, requires up to a year to complete depending on the volume and complexity of measures. On occasion, a project also may be temporarily halted to allow time for the measure developers to change measures in response to NQF requests (for example, two measures of overuse of neck imaging in trauma combined). There were 62 newly endorsed measures resulting from the work conducted during the contract period—14 endorsed prior to the close of the contract period and another 48 awaiting final ratification by the NQF Board (which occurred shortly after the close of the reporting period). See Appendix B for a complete list of newly endorsed measures.

NEWLY ENDORSED MEASURES BY MEASURE TYPE *

Measure type	Number of measures
Outcome	38
Process	8
Patient Experience	6
Resource Use	6
Composite	4
Total	62

*Measures endorsed as a result of HHS contract, 1/14/10 to 2/28/11.

In addition to endorsing new measures, NQF also oversees the updating and maintenance of currently endorsed measures. As a condition of maintaining endorsement, measure developers are required to update their measures to reflect changes in the evidence base. NQF-endorsed measures undergo a comprehensive re-evaluation every three years and must recompete ''head-to-head'' with any new or existing measures for ''best-in-class'' determination. During the contract period, NQF began maintenance of the 47 cardiovascular measures and 44 surgical measures in its portfolio.

NQF also analyzed the implications of the transition from the International Classification of Disease, Ninth Revision, Clinical Modification (ICD–9–CM) to the International Classification of Diseases, Tenth Revision, Clinical Modification and Procedure Coding System (ICD–10–CM/PCS) for quality measurement. As explained in the final report, *ICD–10 CM/PCS Coding Maintenance Operational Guidance* (October 2010, available at *http://www.qualityforum.org/publications/2010/10/ICD-10-CM/PCS_Coding_Maintenance_Operational_Guidance.aspx*), this transition planned for 2013 has significant implications for measure developers, as the majority of NQF-endorsed measures are specified using ICD–9–CM codes.

Technical Infrastructure To Support Measurement Using an Electronic Platform

The American Recovery and Reinvestment Act of 2009 provides $20 billion for investment in health IT and use of that technology to improve patient care. Health IT has the potential to lead to care that is safer, more effective, more affordable, and better coordinated. But to get there, electronic health records (EHRs) and other tools must capture the right data to support performance measurement, and performance measures must be specified to run on an electronic platform. NQF contributions in this area fall into four categories: (1) Development of a Quality Data Model (QDM) that defines the data that must be captured in EHRs and personal health records to support quality measurement and improvement; (2) development of a standard form and an automated tool for measure developers to create eMeasures that can readily be incorporated into vendors' health IT systems; (3) re-specification of 113 performance measures for use with EHRs (*i.e.,* eMeasures); and (4) identification of the types of measures that might be used to ascertain whether EHRs are being used properly by clinicians and to detect any unintended consequences.

The QDM classifies and describes the information needed for quality measurement in a way that health IT vendors understand what data elements to capture (including the most reliable source of the data and the point in time in the care process when it should be recorded), and measure developers know how to specify eMeasures so they will pull the correct information from the EHR. Although the QDM was created in 2009, NQF's Health Information Technology Advisory Committee made important enhancements covered under this contract, such as the development of a comprehensive framework for evolving the model that will accommodate the data needs of new types of measures (*e.g.,* measures of patient engagement in decision-making, long-term functional outcomes, measures that incorporate data on social determinants of health), and updates to data type definitions and elements. The NQF Clinical Decision Support (CDS) Expert Panel also developed a taxonomy of CDS rules and data elements that paves the way for CDS developers to use the QDM in specifying clinical decision support rules (see *Driving Quality and Performance Measurement—A Foundation for Clinical Decision Support* at *http://www.qualityforum.org/Publications/2010/12/Driving_Quality_and_Performance_Measurement_-_A_Foundation_for_Clinical_Decision_Support.aspx*).

To facilitate the specification of eMeasures in a standardized fashion concordant with the QDM, NQF developed a standardized eMeasure format to be used by the more than 50 measure developers. The QDM and eMeasure format taken together will yield important benefits in future years, such as:

- *Reduced health IT costs:* Health IT vendors will be able to identify the data requirements for all the measures in the portfolio of NQF-endorsed measures and will be able to readily incorporate eMeasures from any measure developer in almost a ''turnkey'' fashion.
- *Reduced measure development, testing, and maintenance costs:* Performance measures generally include common components, such as denominators, numerators, exclusions, and sometimes risk-adjustment algorithms. Measure developers may be able to share and reuse certain components of measures (*e.g.,* code sets and rules for identifying patients with Type 2 diabetes on insulin).
- *More useful performance information:* When developers harmonize measures and make use of common definitions and conventions for specifying eMeasures, providers can readily combine measures from different developers into their performance improvement initiatives without introducing ''noise'' into the performance results.

The eMeasure format now is being converted into a software tool known as the Measure Authoring Tool, which will be tested in 2011. NQF will provide training on using the tool to measure developers and others.

The foundational work on the QDM and the eMeasure format conducted in 2009 and 2010 under the contract was critical to the accomplishment of another important objective—the re-specification of 113 measures from paper-based format to eMeasure format. In response to an HHS request to develop eSpecifications for measures currently being used by HHS for public reporting, payment, quality improvement, or other purposes, NQF worked in coordination with the 18 developers of these measures to convert the measures from their current format into the eMeasure format. These eMeasures, along with detailed specifications, can be found on the NQF Web site at *http://www.qualityforum.org/Projects/e-g/eMeasures/Electronic_Quality_Measures.aspx?section=PublicandMemberComment2011-02-012011-04-01.* HHS is using many of the re-specified measures to assess meaningful use of health IT for purposes of awarding incentive payments in 2011.

The fourth and final area of NQF's health IT work focused on answering the question, ''How will we know if health IT is being properly used by clinicians to provide better care?'' To achieve the full potential of health IT to enhance the safety, effectiveness, and affordability of care, clinicians must use the technology as intended. For example, reductions in medication errors will be achieved only if clinicians do not disable or ignore alerts for potential drug interactions. In the report *Driving Quality—A Health IT Assessment Framework for Measurement* (2010, available at *http://www.qualityforum.org/Publications/2010/12/Driving_Quality_-_A_Health_IT_Assessment_Framework_for_Measurement.aspx*), NQF identifies potential types of measures that might be developed and incorporated into EHRs to provide information on when and how the technology is being employed by front-line providers, which in turn can be used to determine if there is a need for more user-friendly interfaces, modifications in work flow, or clinician education and training programs. The report also identifies types of measures that, if incorporated into EHRs, would provide early warning signs of unintended consequences (*e.g.,* selection of an inappropriate order set based on the patient's active diagnoses).

Measure Selection for Applications

Setting National Priorities and Goals serves as an important starting point for selecting measures, but for most applications there are additional considerations. In response to a request from the Office of the National Coordinator for Health IT (ONC), NQF prepared a ''quick turnaround'' report in the summer of 2010 to assist HHS leadership and the Health IT Policy Committee in identifying a parsimonious set of measures that might be used in 2013 to assess meaningful use of health IT. The NQF report *Identification of Potential 2013 e-Quality Measures* (August 2010, available at *http://www.qualityforum.org/projects/i-m/meaningful_use/meaningful_use.aspx*), finalized in August 2010, used the six national priorities identified by NPP as an organizing framework; proposed five criteria that have been utilized to identify measures in each priority area; and based on a review of measures in the NQF portfolio and an environmental

scan of measures used by leading health systems, identified available measures that might be adapted for use in 2013 and beyond.

Summary

This is an extraordinary period of challenges and opportunities for our country's healthcare system. Reforming the healthcare delivery system to provide care that is safe, effective, and affordable necessitates changes in the environment of care. As the Institute of Medicine noted a decade ago in its landmark report *Crossing the Quality Chasm,* public reporting, value-based payment, a national health information network, and programs for dissemination of knowledge and tools are key elements of creating an environment of care that enables and rewards improvement.

Fundamental building blocks for all of these efforts are a vigorous quality measurement enterprise including national priorities that focus our efforts on high-leverage areas with the greatest potential to produce better health and healthcare; the ability to measure, report, and reward performance results; and the ability to share best practices. Building such an enterprise is a shared responsibility of many stakeholders in the public and private sector. NQF is thankful for the opportunity to contribute.

Note: 1. U.S. Congress, *Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148),* Washington, DC: U.S. Government Printing Office; 2010. Available at *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.* Last accessed December 2010.

II. About the National Quality Forum

NQF was created in 1999 as a national standard-setting organization for healthcare performance measures. NQF is governed by a Board of Directors that includes healthcare leaders from the public and private sectors, with a majority of its at-large seats held by consumers and those who purchase services on consumers' behalf. A multi-stakeholder organization, NQF's more than 430 members are organized into eight councils—consumers; purchasers; healthcare professionals; health plans; provider organizations; public/community health agencies; quality measurement, research, and quality improvement organizations; and suppliers and industry—thus drawing on the expertise and insight of every sector of the healthcare field.

In establishing national consensus standards, NQF adheres to the National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113) [1] and the Office of Management and Budget's formal definition of consensus.[2] NQF endorses performance measures, preferred practices, serious reportable events, and measurement frameworks through its formal Consensus Development Process (CDP),[3] which provides for extensive multi-stakeholder input. The strict adherence to this CDP qualifies NQF as a voluntary consensus standards-setting organization, granting its endorsed measures special legal standing.

NQF Consensus Development Process

1. Call for Intent to Submit Candidate Standards
2. Call for Nominations
3. Call for Candidate Standards
4. Candidate Consensus Standard Review
5. Public and Member Comment
6. Member Voting
7. Consensus Standards Approval Committee (CSAC) Decision
8. Board Ratification
9. Appeals

The NQF portfolio of voluntary consensus standards includes performance measures, serious reportable events, and preferred practices (*i.e.,* safe practices). A complete list of measures included in the NQF portfolio can be found at *http://www.qualityforum.org/Measures_List.aspx.* There are measures applicable to nearly all healthcare settings (*e.g.,* ambulatory settings, hospitals, nursing homes, home health agencies, health systems) and types of clinicians (*e.g.,* primary care providers, specialists). NQF uses a two-dimensional framework to organize the measures in its portfolio:

- *Cross-cutting areas:* measures that affect all or most patients, such as safety, care coordination, and overuse; and
- *Clinical areas:* measures that apply to patients with specific conditions, such as diabetes, asthma, or congestive heart failure.

Approximately one-third of the measures in NQF's portfolio are measures of patient outcomes (*e.g.,* mortality, readmissions, health functioning, depression screening tool that assesses emotional status and social engagement), or experience of care (*e.g.,* satisfaction). Most of the remaining measures are measures of care processes that can be linked to better outcomes (*e.g.,* medication reconciliation, annual eye and foot exam for patients with diabetes). Approximately 20 percent of endorsed measures relate to the important area of patient safety. The NQF-endorsed Safe Practices for Better Healthcare provide an evidence-based approach to improving patient safety.

The measures included in the NQF portfolio are owned or sponsored by 53 different stewards, which include: Public agencies (*e.g.,* the Centers for Medicare & Medicaid Services [CMS], the Agency for Healthcare Research and Quality), state and community entities (*e.g.,* Minnesota Community Measurement), professional societies (*e.g.,* Physician Consortium for Performance Improvement convened by the American Medical Association, Society of Thoracic Surgeons), accrediting organizations (*e.g.,* the National Committee for Quality Assurance, The Joint Commission), health plans, academic and research institutions, health systems, and others. The portfolio has become a rich resource for national, state, and community-level initiatives that seek the best performance measures to use in public reporting, payment, and quality improvement initiatives.

In recent years, NQF has worked closely with the Department of Health and Human Services (HHS) and measure stewards to re-specify performance measures for use with interoperable electronic health records (EHRs) and personal health records. To date, more than 110 measures have been ''retooled.'' HHS currently uses these retooled measures for activities including ''meaningful use'' measurement in the Electronic Health Records Incentive Programs, the Medicare Hospital Compare public reporting program, and in various value-based payment programs. NQF has encouraged measure stewards to adopt common conventions in specifying eMeasures and in identifying the types of data that must be captured in electronic health records to support quality measurement and improvement.

In addition to its role as a standard-setting body, NQF also serves as the neutral convener of two national multi-stakeholder partnerships. The National Priorities Partnership (NPP) was established in 2007 to set national priorities and goals for performance improvement and released its first report shortly thereafter identifying six original major priority areas: (1) Patient and family engagement, (2) population health, (3) patient safety, (4) care coordination, (5) palliative and end-of-life care, and (6) overuse. NPP currently consists of 42 leading private-sector organizations—including consumers, purchasers, health plans, providers, health professionals, accreditation/certification bodies—and six Federal agencies. These NPP leaders have worked closely over the past three years

to identify priorities for healthcare quality improvement and to engage a broad group of stakeholders in coalescing around these priorities to drive change. In September 2010, in response to a request from HHS, NPP provided input regarding priorities for the 2011 HHS National Quality Strategy.[4] A second multi-stakeholder partnership is the Measure Applications Partnership (MAP). This very new group, still in the formative stages, will be convened for the first time in 2011 to provide input to HHS on the selection of measures for use in various public reporting and payment programs.

In recent years, NQF also has enhanced its health information technology portfolio to contribute to the creation of an interoperable electronic infrastructure that supports quality measurement and improvement. This began with NQF's construction of the Quality Data Model (QDM), a classification system that describes clinical and other information used for quality measurement and provides a standardized terminology to be used in constructing eMeasures. NQF also is working on a Measure Authoring Tool to help measure developers build eMeasures.

Notes

1. U.S. Congress, National Technology Transfer and Advancement Act of 1995 (PL 104–113), Washington, DC: U.S. Government Printing Office, 1995. Available at *http://standards.gov/standards_gov/nttaa.cfm.* Last accessed December 2010.

2. The White House, *U.S. Office of Management and Budget. Circular No. A–119, February 10, 1998,* Washington, DC: U.S. Office of Management and Budget, 1998. Available at *http://www.whitehouse.gov/omb/circulars_a119/.* Last accessed December 2010.

3. National Quality Forum (NQF), *NQF Consensus Development Process, v. 1.8.* Available at *http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx.* Last accessed December 2010.

4. National Priorities Partnership. *Input to the Secretary of Health and Human Services on Priorities for the 2011 National Quality Strategy.* Washington, DC: NQF; 2010. Available online at *http://www.nationalprioritiespartnership.org/uploadedFiles/NPP/Non-Partners/Newsletters/NPP%20Input%20to%20HHS%20on%20Priorities%20for%202011%20National%20Quality%20Strategy_Final%20Report%282%29.pdf.* Last accessed February 2011.

III. About the Contract

The Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) is a wide-ranging law that addresses many aspects of Medicare and Medicaid, including the addition of new benefits for Medicare beneficiaries. Among other things, the Act directs the Secretary of HHS to contract with a consensus-based entity for certain activities relating to healthcare performance measurement.

On January 14, 2009, NQF was awarded a contract, HHSM–500–2009–00010C, under the Act's Section 183. This contract is administered by HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE), which provides strategic leadership and technical and management oversight for the contract, and by CMS, which provides technical input and operational support. The contract provided up to $10 million for the first year after award, with the option for three $10 million annual renewals through 2012. It calls for NQF to:

- Develop a prioritized list of conditions that impose a heavy health burden on beneficiaries and account for significant costs;
- Identify and endorse measures that various stakeholders can use to assess and improve the care provided to beneficiaries with these conditions, and the performance of providers in various healthcare settings;
- Identify programs to track and disseminate measures;
- Ensure performance measures are regularly and appropriately updated and remain relevant for public reporting and improvement;
- Promote the use of EHRs for performance measurement, reporting, and improvement; and
- Report annually to Congress on the status of the project and progress to date.

This contract had the effect of providing a mandate and stable funding to NQF, granting the organization a source of core funding to pursue this important work in a coordinated, strategic manner. While the work conducted under the contract is intended specifically to benefit all those served by HHS programs, it will have the salutary additional benefit of improving care for all Americans. The work being conducted under this contract directly relates to NQF's core competencies in three areas:

- *Building consensus on National Priorities and Goals:* NQF has convened leaders from major stakeholder groups and through this process has identified National Priorities and Goals for Performance Improvement. This work provides a foundation for the priority-setting efforts under this contract, which focus on clinical conditions. The priorities identification work served as a guide for measure gap analysis and informs work going forward that will result in a harmonized portfolio of high-leverage measures.
- *Endorsing performance measures:* NQF has endorsed more than 625 performance measures and preferred practices under its formal CDP, granting those measures and practices special legal standing as voluntary consensus standards, working toward a goal of achieving a comprehensive yet parsimonious set of performance measures *that map to national priorities and fill critical gaps.*
- *Facilitating the development of performance measures specified for use with electronic health records and personal health records, referred to as eMeasures:* NQF has worked to identify the types of information that need to be included in an EHR to enable electronic reporting on quality metrics and has coordinated the efforts of measure developers to retool 113 measures for use on an electronic platform.

Under the contract, HHS asked that performance measures focus on ''outcomes and efficiencies that matter to patients, align with electronic collection at the front end of care, encompass episodes of care when possible, and will be attributable to providers where possible.''

The work under this contract is divided into 13 tasks. Six of the tasks are procedural—involving an opening meeting, the development of a work plan, the development and implementation of a quality assurance Internal Evaluation Plan, weekly conference calls, monthly progress reports, and the creation of this annual report. The remaining seven call for specific deliverables and are the focus of this report.

Task 6 is the formulation of a national strategy and priorities for healthcare performance measurement. Task 7 is the implementation of a consensus process for endorsing healthcare quality measures. This task includes an evaluation of NQF's consensus development process and the conduct of endorsement projects focusing on known measure gap areas. Task 8 is the maintenance of previously endorsed NQF measures. Task 9 is the promotion of EHRs. Task 11 is the development of a public Web site for project documents. Task 12 calls for measure development, harmonization, and endorsement efforts to fill critical gaps in performance measurement. In 2010, Congress passed the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), which directed HHS to contract with a consensus-based entity to provide multi-stakeholder input into the National Quality Strategy, as well as the

selection of measures for use in various programs by CMS and, potentially, other federal agencies. This contract was modified to perform additional work under Section 3014 of the Affordable Care Act. That work, Task 13, was the convening of the NPP to advise the Secretary of HHS on the development of the National Quality Strategy.

Details of work performed under the HHS contract in each of these tasks are found in Section IV of this report.

IV. HHS-Funded Work

This section describes details of work performed under each task according to the HHS contract in 2010. Appendix A is a summary of the accomplishments under the contract. Appendix C is a list of all final reports produced with links to where they can be found on the NQF Web site.

National Strategy and Priorities (Task 6)

Forming a strategy and setting priorities for performance improvement is crucial to focusing resources on areas that will produce the greatest improvements in terms of better health and healthcare. In 2007, NQF convened NPP, co-chaired by Margaret O'Kane, president of the National Committee for Quality Assurance, and Bernard Rosof, MD, chair of the Physician Consortium for Performance Improvement convened by the American Medical Association. In work predating this contract, NPP identified six priorities as those with the greatest potential to eradicate disparities, reduce harm, and remove waste from the American healthcare system. In its recent report to the Secretary, NPP added two additional priorities. *(See Task 13.)*

Building upon this foundation, in work funded under this contract, NQF undertook the following projects:

- Prioritizing high-impact Medicare conditions and associated measure gaps (Task 6.0);
- Setting a national measure development and endorsement agenda (Task 6.2);
- Analyzing measures targeted under the Meaningful Use portion of the Medicare Electronic Health Record Incentive Program, specifically examining how health IT tools can improve the efficiency, quality, and safety of healthcare delivery (Task 6.4);
- Investigating the use of NQF-endorsed measures (Task 6.1); and
- Analyzing measures being used to gauge quality of care for people with multiple chronic conditions (Task 6.3).

Prioritization of Medicare High-Impact Conditions

In May 2010, NQF published *Prioritization of High-Impact Medicare Conditions and Measure Gaps.*[1] This report was based on the work of NQF's Measure Prioritization Advisory Committee, which prioritized the top 20 high-impact Medicare conditions[2] that account for more than 90 percent of Medicare costs *(see below).* The committee considered multiple dimensions in its analysis, including: cost; prevalence; the potential for improving quality, efficiency, and patient-centeredness; the potential for reducing overuse and waste; variability in provider performance and care delivery; and disparities. In related work under this contract, NQF is endorsing outcome measures for these 20 high-impact conditions. *(See Task 7.1.)*

*Prioritized List of 20 High-Impact Medicare Conditions**

(1) Major depression
(2) Congestive heart failure
(3) Ischemic heart disease
(4) Diabetes
(5) Stroke/transient ischemic attack
(6) Alzheimer's disease
(7) Breast cancer
(8) Chronic obstructive pulmonary disease
(9) Acute myocardial infarction
(10) Colorectal cancer
(11) Hip/pelvic fracture
(12) Chronic renal disease
(13) Prostate cancer
(14) Rheumatoid arthritis/osteoarthritis
(15) Atrial fibrillation
(16) Lung cancer
(17) Cataract
(18) Osteoporosis
(19) Glaucoma
(20) Endometrial cancer

* As determined by NQF Measure Prioritization Advisory Committee under contract to HHS.

Measure Development and Endorsement Agenda

The work on prioritization of conditions fed directly into a related project under this task—the creation of a measure development and endorsement agenda. This prioritization project provides guidance on how best to invest measure development resources and will assist NQF in helping the portfolio of endorsed measures evolve to be most useful for public reporting, performance-based payment, and quality improvement.

The Measure Prioritization Advisory Committee considered the performance measure needs of Medicare, child health, and population health. Key objectives included alignment with the measures needed for new approaches to public reporting and payment in the Affordable Care Act and for the meaningful use provisions in the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5). The Measure Prioritization Advisory Committee considered the following: priorities for improvement previously identified by NPP; priorities identified by measure developers; key areas identified during health information technology meaningful use deliberations; disparities-sensitive measure gaps; and gaps identified during previous NQF endorsement activities. The final report, *Measure Development and Endorsement Agenda* (published in January 2011 and available at *http://www.qualityforum.org/MeasureDevelopmentandEndorsementAgenda.aspx#t=2&s=&p=4%7C*), provides prioritized lists of measure gaps in eight areas:

- Resource use/overuse,
- Care coordination and management,
- Health status,
- Safety processes and outcomes,
- Patient and family engagement,
- System infrastructure supports,
- Population health, and
- Palliative care.

Measures for Meaningful Use

In spring 2010, HHS's Office of the National Coordinator for Health Information Technology (ONC) requested a rapid analysis of the types of measures that might be selected to assess meaningful use of health information technology (health IT) in 2013 and a preliminary scan of whether such measures currently are available or could be developed, tested, and endorsed within the requisite timeframe. This project, which became Task 6.4 under the HHS contract, provided a framework for considering various types of measures and an inventory of available EHR-based measures from leading sources. A report, *Identification of Potential 2013 e-Quality Measures,* which was published in August 2010, used the six national priorities identified by NPP as an organizing framework; proposed five criteria that the Health IT Policy Committee and HHS leadership could use to identify a parsimonious set of measures in each priority area; and, based on a review of measures in the NQF portfolio and an environmental scan of measures used by leading health systems, identified available measures that might be adapted for use in 2013. The report also identified potential methodological issues that need to be

addressed before further measure adaptation or *de novo* measure development.

NQF also began two projects under this task order that are currently in process: measure use evaluation (Task 6.1) and the development of an endorsed performance measurement framework for patients with multiple chronic conditions (Task 6.3). For evaluating uses of NQF-endorsed measures, NQF has engaged RAND to conduct an independent, third-party assessment on uptake of endorsed measures for such purposes as payment, public reporting, quality improvement, and accreditation/certification, as well as to examine success factors and implementation barriers. To support the development of a performance measurement framework for patients with multiple chronic conditions, NQF is in the process of engaging researchers to draft a white paper highlighting key measurement-related issues for these patients. A multi-stakeholder committee will consider that input and recommend a measurement framework. The framework will inform future work pertaining to the endorsement of measures of performance for patients with multiple chronic conditions.

Implementation of a Consensus Process for the Endorsement of Quality Measures (Task 7)

Valid, meaningful measures of performance make it possible to gauge the quality of healthcare and focus quality improvement efforts by helping identify what is working and what needs additional improvement. Stakeholder-based endorsement of performance measures via a formal endorsement process has long been NQF's stock in trade. This task involves both a formal evaluation of the endorsement process and a set of consensus projects focused on known measure gap areas.

In the past year, NQF has engaged in several HHS-funded measure endorsement projects and related projects. These have included:

- Measures of performance on healthcare outcomes (Task 7.1);
- Measures of patient safety and other projects specifically related to patient safety (Task 7.3);
- Measures of performance on palliative care (Task 7.4);
- Measures of performance in nursing homes (Task 7.5);
- An evaluation of NQF's consensus development process, with an eye toward making the process more efficient and user friendly (Task 7.6); and
- Measures of performance of care delivered to children (Task 7.8).

Outcome Measures Project

NQF's outcome measures project focused on areas with the greatest potential impact, including common conditions, gaps in measurement of patient-focused outcomes, and transitions across care settings. The first two cycles of this three-cycle project concentrated on the Medicare 20 high-impact conditions list, while the third cycle focused on child and mental health. A significant amount of this work has been completed, resulting in the endorsement of 35 outcome measures.

Outcome measures endorsed as a result of the HHS contractcross-cutting area	Number of measures
Care Coordination	6
Functional Status	2
Healthcare System (readmissions, length of stay)	3
Patient Experience and Engagement	2
Safety (complications, adverse events)	18
Social Determinants	4

Patient Safety

Under the HHS contract in 2010–2011, NQF engaged in four significant patient safety activities:

- *Serious Reportable Events in Healthcare:* NQF's work in this area dates from 2002, when it published its first report listing 27 events that are avoidable and have serious consequences for patients. The project's objective was to establish consensus among consumers, providers, purchasers, researchers, and other healthcare stakeholders about those preventable adverse events that should not occur and to define them in a way that, should they occur, it would be clear what had to be reported. This report was updated in 2006, with one additional event being added. *Serious Reportable Events* has become the foundation of HHS's program of denial of payment for certain hospital-acquired conditions and for many state-based adverse event reporting initiatives. Under the HHS contract, NQF is reviewing the *Serious Reportable Events,* which originally focused on the hospital setting, with an eye toward expanding the list of events and their reach to three new environments of care: ambulatory practice settings (specifically, office-based physician practices); long-term care settings (specifically, skilled nursing facilities); and office-based surgery centers. The list of events also is being expanded to include events that are ''largely preventable'' in addition to those that are entirely preventable. The public comment period for the 29 updated and proposed new *Serious Reportable Events* has closed, and NQF expects to finalize its revision in spring 2011.
- *Patient safety measures:* Currently a multiphase project is underway to identify and endorse patient safety measures. These include measures on medication safety and preventing healthcare-associated infections. Final endorsement of these measures and completion of this project are slated for spring 2011.
- *Public reporting framework for patient safety:* Under the HHS contract, NQF in 2010 completed a consensus development project that resulted in the endorsement of a framework for public reporting of patient safety event information. The intention is for reporting entities to use this framework, *National Voluntary Consensus Standards for Public Reporting of Patient Safety Event Information,* to create a more uniform approach to public reporting.
- *Improving patient safety through state-based reporting in healthcare:* To date, 26 states and the District of Columbia have enacted reporting systems to help practitioners identify and learn from major adverse events. The majority of those states incorporate at least some portion of the NQF list of *Serious Reportable Events* to help establish a more uniform set of criteria by which to report. There remains incongruity among states, however, in the use, implementation approaches, and perspectives toward reporting a variety of patient safety events and, in turn, efforts for improving adverse outcomes from these events. Under the contract, NQF has developed an ongoing effort to engage representatives of states with reporting systems to facilitate communication and inform NQF about successes, barriers, and unintended consequences within adverse event reporting at the state level, including use of NQF's *Serious Reportable Events.*

Palliative Care

Hospice and palliative care services offer physical, emotional, and spiritual care to patients coping with severe or end-of life-illnesses. These programs also help coordinate care of multiple specialists to ensure pain is alleviated and help patients and their families make difficult decisions regarding treatment goals. Unfortunately, more than 1 million people die each year without ever having access to these important services. Many of those lacking adequate access will endure

prolonged and needless suffering and ineffective treatments.

In 2006, NQF endorsed a framework and preferred practices for palliative and hospice care quality.[3] NPP has identified palliative care as a priority area for national action. In 2010, NQF began planning for a project that would seek to endorse performance measures to gauge the quality of palliative and end-of-life care. This project is slated to begin in early 2011.

Nursing Homes

NQF was an early pioneer in advancing measures of nursing home care quality, endorsing an initial set of performance measures in this area in 2004.[4] Building on this work, in 2009 NQF initiated a project to consider additional performance measures for chronic and post-acute care nursing facilities. The measures evaluated were intended to provide tools for regulators, purchasers, and consumers to evaluate the quality of care in these facilities, as well as metrics facilities can use to assess and improve the quality of care they provide. As a result of this project, 21 measures were endorsed. These measures evaluate the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. Appendix B provides information on these measures.

Evaluation of the Consensus Development Process

NQF uses its formal endorsement process to evaluate and endorse consensus standards, including performance measures, preferred practices, frameworks, and reporting guidelines. The process is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry. *(For details on how the process works, please see Appendix G.)* Because NQF uses this formal process, it is recognized as a voluntary consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of 1995 and Office of Management and Budget Circular A–119.

Just as NQF asks the healthcare system to measure, report, monitor, and constantly improve, the organization expects constant improvement of its own systems, policies, and processes. Thus, under the HHS contract in 2010, NQF engaged subcontractor Mathematica Policy Research, Inc., to evaluate its consensus process. This comprehensive analysis included a technical process analysis, stakeholder analysis, and scan of comparative alternatives. The reviewers found that the NQF consensus process is generally well regarded among its stakeholders; nevertheless, they did suggest specific refinements of the process's timeliness, efficiency, and effectiveness. The final report, *Assessment of the National Quality Forum's Consensus Development Process,* was submitted to NQF in December. In response to the recommendations, NQF already has identified some refinements to the process as described in *NQF Consensus Development Process 2010—A Year in Review* and is considering how to refine its consensus process further.

Child Health Measures

Child health quality is an important, underemphasized area of measure development and endorsement. To date, NQF has endorsed more than 70 pediatric and perinatal measures, with emphasis in the areas of perinatal and neonatal care, chronic illness care, and care for hospitalized children. However, the need for child health quality measures has outpaced the number of available endorsed measures. The recent release of an initial core set of measures for Medicaid and CHIP (Children's Health Insurance Program) voluntary use provides an important step in assessing child health quality by state programs. The Agency for Healthcare Research and Quality National Advisory Council Subcommittee on Children's Healthcare Quality Measures for Medicaid and CHIP Programs (AHRQ SNAC) has identified a number of child health priority areas without adequate measures, including mental health and substance abuse services, other specialty services, and inpatient care.

To assist in these efforts, NQF has embarked on a consensus project to endorse additional measures of child health quality in a project that will complement the AHRQ SNAC collaboration with CMS, CHIP, and Survey and Certification. While the initial core set of Children's Health Insurance Program Reauthorization Act (CHIPRA) measures will be specified by the Secretary of HHS, there may be other appropriate measures that could enhance the portfolio of child health quality measures and could be used in the future for the pediatric quality measurement program as required by CHIPRA. NQF's current project in this area targets measures that could be used in public reporting at the population level (*e.g.,* state) and for certain conditions or cross-cutting areas applicable to the Medicaid population. This project is expected to be completed in summer 2011.

Maintenance of Previously Endorsed NQF Measures (Task 8)

NQF endorsed its first performance measures in 2001. Since then, much has changed about healthcare, performance measurement, the technologies supporting patient care and documentation (which enable performance measurement and reporting), and the NQF endorsement process itself. The science supporting quality measurement and medicine itself is rapidly evolving, and, of particular note, the science and technology of care delivery have changed. It is critically important that NQF keep pace with these changes. Simply put, it is unreasonable and counterproductive to all parties to gauge performance based on anything other than the most up-to-date, best-in-class measures.

NQF has endorsed more than 625 measures. Ensuring these measures remain up to date—a process known as ''measure maintenance''—is a time-consuming and resource-intensive task, but a necessary one. Endorsed measures must be re-evaluated against NQF's measure evaluation criteria[5] and reviewed alongside newly submitted (but not yet endorsed) measures. This head-to-head comparison of new and previously endorsed measures fosters harmonization *(please see Task 12.2 for a description of harmonization)* and helps ensure NQF is endorsing the best available measures.

NQF Measure Maintenance Cycles

CYCLE A–1	CYCLE B–1	CYCLE C–1
Cardiovascular-1	Cancer	Healthcare infrastructure
Surgery-1	Pulmonary/critical care	HEENT
Prevention	Safety-1	Infectious disease
Cardiovascular-2	Disparities	Neurology
Surgery-2	Palliative and end-of-life care	Patient experience and engagement
Endocrine	Perinatal	Functional status

NQF MEASURE MAINTENANCE CYCLES—Continued

CYCLE A–1	CYCLE B–1	CYCLE C–1
GU/GYN	Renal	GI
Mental health	Care coordination	
Musculoskeletal	Safety-2	

Under the HHS contract in 2010, NQF finalized a process for the systematic, complete maintenance of all of its endorsed measures. This process involves reviewing all endorsed measures across 22 topic areas every three years. The numbers of topic areas and measures are subject to change in the future depending on the type and volume of new measures received in upcoming projects. NQF also began work using this new endorsement maintenance process on two major areas for measure maintenance: Cardiovascular and surgery measures. These projects are scheduled for completion later in 2011.

Promotion of Electronic Health Records (Task 9)

The opportunity to improve healthcare through health IT has never been greater. The American Recovery and Reinvestment Act of 2009 provides a $20 billion mandate to ensure health IT plays a central role in transforming care through the EHR Incentive Program and its meaningful use provisions, while the Affordable Care Act ensures that performance measures, supported by an electronic infrastructure, drive a national strategy for quality improvement. Health IT will help ensure care is safer, more affordable, and better coordinated. But to get there, a common language among systems is necessary, and EHRs and other tools must capture the right data to support performance measurement. This will give actionable data to providers, patients, and others working to improve quality.

NQF and Health IT: Putting It in Context

To understand NQF's accomplishments in health IT in 2010–2011, it is important to understand two projects that NQF previously completed in this area:

1. *The Quality Data Model (QDM, formerly known as the Quality Data Set, or QDS):* The QDM, developed by NQF's Health Information Technology Expert Panel (HITEP), is a set of data elements or types of data elements that can be used as the basis for developing harmonized and machine-computable performance measures. It is a classification system that describes clinical quality information so that it may be shared for quality measurement, clinical research, and public health, all of which repurpose information recorded during clinical care. As the QDM is applied to new measures, measure retooling efforts, and supporting EHR use, the model will evolve, requiring oversight and expert advice. The QDM provides direction to measure developers, EHR vendors, and other stakeholders on how to define quality terminology without ambiguity. Although the QDM was developed under an earlier grant from the Agency for Healthcare Research and Quality, its implementation is covered under the current HHS contract. For more information about the QDM, please visit *http://www.qualityforum.org/Projects/h/QDS_Model/Quality_Data_Set_Model.aspx.*

2. *The ''eMeasure'':* The eMeasure is the electronic format for representing a performance measure in a machine-readable electronic format. Through standardization of a measure's structure, metadata, definitions, and logic, the eMeasure provides quality measure consistency and unambiguous interpretation. The eMeasure is becoming part of NQF's measure submission, endorsement, and maintenance requirements. This work was performed in 2009–2010 under the HHS contract as Task 9.3.

NQF's health IT portfolio supports the creation of this electronic infrastructure. In 2010–2011 under the HHS contract, NQF undertook several projects in health IT, including:

- The development of a measure authoring tool (Task 9.1);
- The convening of a Clinical Decision Support Expert Panel (Task 9.2);
- Maintenance of its previously developed Quality Data Model (Task 9.5);
- The convening of a Health IT Utilization Expert Panel (Task 9.6);
- Measure retooling for EHRs (Task 9.7); and
- The convening of an eMeasure Format Review Panel (Task 9.8).

Measure Authoring Tool

Under the HHS contract, NQF is sponsoring the development of a software tool that measure developers will use to create the eMeasure. The tool will be Web based, easy to use, and maintained over time for use in NQF's measure submission process. It will allow a measure developer, knowing clinical concepts, to enter information into the tool and come out with a standard healthcare quality measure format in what is known as Extensible Markup Language, or XML, that any EHR can implement. NQF has engaged a subcontractor, the Iowa Foundation for Medical Care, to develop this tool. It is anticipated that the measure authoring tool will be available for public use by late 2011.

Clinical Decision Support Expert Panel

Properly positioned within an EHR system, clinical decision support (CDS) tools can play an important role in matching patient information with relevant clinical knowledge, thereby helping clinicians incorporate that knowledge into decision-making. CDS is an essential capability of health IT systems; however, a common classification or taxonomy is necessary to enable system developers, system implementers, and the quality improvement community to develop tools, content, and policies that are compatible and support CDS features and functions. In 2010, under the HHS contract, NQF convened an Expert Panel with expertise in CDS and performance measurement. The members of the panel assisted in identifying best practices and reducing duplicative or uncoordinated efforts. In December, the panel published the report *Driving Quality and Performance Measurement—A Foundation for Clinical Decision Support,* featuring a taxonomy for CDS that represents CDS rules and elements, while ensuring concordance with the Quality Data Model (QDM).

Quality Data Model Maintenance

The QDM is a model of presenting information that allows measure developers to express what they want to say, or what information they want to pull from a health record, in a way that EHRs can understand. To ensure the value and use of the QDM, NQF will enhance it periodically in response to evolving needs for performance measurement. While the QDM was created under a separate contract, its maintenance and revision is covered

under the HHS contract. The QDM Version 2.1 is the most current, containing updates to QDM data type definitions as well as additional elements updates, based on comments received on the QDM Version 2 in July 2010. The next version of the QDM will be posted for public comment in spring 2011, following a semi-annual update schedule.

Health IT Utilization Expert Panel

Proper use of health IT (*e.g.,* EHRs, personal health records) and its core features and functions is essential to improving quality of care. However, health IT also can have unintended consequences and introduce safety hazards (*e.g.,* wrong drug chosen due to proximity on the screen to another drug, problem list fails to show all problems). Thus, in 2010, under the HHS contract, NQF convened an expert panel to examine the information needed to measure effective health IT use in order to understand better how health IT tools can improve the efficiency, quality, and safety of healthcare delivery. The panel created a model to measure health IT use, establishing a taxonomy of different types of performance measures that might be developed to assess whether health IT is being used properly by clinicians and others, including assessing whether decision support tools are being used effectively and methods of detecting hazards. The project also identified methods of testing health IT utilization measures and type and level of evidence necessary to support endorsement and will provide guidance pertaining to system certification requirements. The panel published its report, *Driving Quality—A Health IT Assessment,* in December 2010.

Measure Retooling for EHRs

At the request of HHS, NQF in 2010 managed the conversion, or ''retooling,'' of a set of 113 measures from their paper-based format to the eMeasure format, working in coordination with their original 18 developers. These NQF-endorsed quality measures needed to be converted so that the data elements are defined using the eMeasure format and in the context of EHR usage. The goal is to measure quality directly out of EHRs. These measures, a mix of inpatient and ambulatory measures, were chosen by HHS for retooling for potential inclusion in the CMS EHR Incentive Program. The 113 measures, along with detailed eSpecifications, eMeasure code list descriptors, and a guide to how to view and interpret an electronic measure, can be found on the NQF Web site at *http://www.qualityforum.org/Projects/e-g/eMeasures/Electronic_Quality_Measures.aspx.*

The first 44 measures produced were included in the July 2010 Meaningful Use Stage 1 measures. The project included a complete review of efforts required to convert paper-based measures to eMeasure format, including use of the QDM and guidance on how to present logic and timing for each element in a standard manner. NQF incorporated feedback from a large number of public comments in the model used for the final product delivered to HHS. The information learned also was incorporated into the measure authoring tool software development effort. This project was completed under the HHS contract in 2010.

eMeasure Format Review Panel

Closely related to the measure retooling project, NQF in 2010 under the HHS contract convened a body of experts to participate in a panel to conduct a transparent and thorough review of the retooled measures. This panel will oversee an eMeasure review process to evaluate the specifications (structure) and intent (content) of retooled measures. This evaluation ensures that a measure's intent remains intact for continued NQF endorsement. The review panel's work is ongoing.

Development of a Public Web Site (Task 11)

The HHS contract provided funding for NQF to revamp and maintain its Web site, *http://www.qualityforum.org,* to allow measure developers, members, and the public easier access to relevant documents.

Under the HHS contract, NQF in 2010 substantially overhauled its Web site, developing and maintaining content and supporting materials for numerous HHS-supported consensus development projects and other tasks, and adding web analytics to make it easier to determine the actual needs of public consumers seeking information about NQF projects. To facilitate access to endorsed measures, NQF has established a measures database that will be considerably enhanced in 2011 with more advanced search capabilities. NQF also has streamlined its web submission forms to reduce time to process items, created a new health IT content area to reflect the health IT work conducted under this contract, and created commenting tools that allow for open-ended or guided public comments. The Web site now features a content management system with an online measure submission form, an online public and member comment capability, and online voting platform for members. Important pages on the Web site include:

- A page containing all MIPPA-funded consensus development activity, *http://www.qualityforum.org/Projects.aspx;*
- A home for all of its health IT activity, *http://www.qualityforum.org/Topics/Health_Information_Technology_(HIT).aspx;* and
- An online measure submission form, which can be accessed through *http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx.*

Further enhancements planned for 2011 include integrating the Measure Authoring Tool to allow seamless access to measure developers needing to develop eMeasures.

Measure Development, Harmonization, and Endorsement to Fill Gaps (Task 12)

The HHS contract provides for measure development and related activities to fill immediate areas of need that HHS has identified. In 2010, HHS requested work in four areas:

- Efficiency and resource use (Task 12.1);
- Measure harmonization (Task 12.2);
- ICD–10 conversion guidance (Task 12.3); and
- Emergency regionalization (Task 12.5).

Efficiency and Resource Use

Under the HHS contract, NQF in 2010 conducted in two projects related to efficiency. The first focuses on endorsing measures of imaging efficiency, noting that Medicare spends approximately $14 billion annually on outpatient imaging studies.[6] At the close of the reporting period, NQF had sent six imaging efficiency measures to the Board for ratification. (All were subsequently endorsed shortly after the close of the reporting period.) The second project was a white paper on resource use measures, which was posted for public comment in the fall of 2010. This draft white paper, now being revised to respond to HHS and public input, will inform a consensus development project, ongoing in 2011, that will endorse a set of resource use measures to gauge the cost of healthcare services provided.

Harmonization

The current quality landscape includes many quality reporting initiatives and measure developers, as well as a proliferation of measures. Separate quality initiatives—focusing on different settings and patient

populations—often lead to duplicative or overlapping measures. Multiple measures with varying specifications that have essentially the same focus can create confusion in choosing measures for implementation, while differences in measure specifications limit comparability and understanding of measure results across settings or patient populations. Thus, it is necessary to adopt more global, ''harmonized'' quality measures in all settings.

In 2010, under the HHS contract, NQF convened a Steering Committee to develop operational guidance for achieving harmonization within future NQF consensus development projects. The final project report, *Guidance for Measure Harmonization,* was competed in January 2011.

ICD–10 Conversion

In 2013, one of the code sets that HHS uses to classify healthcare will be upgraded. This transition from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) codes to the International Classification of Diseases, Tenth Revision, Clinical Modification and Procedure Coding System (ICD–10–CM/PCS) has implications for quality measurement because a majority of the diagnoses used to define NQF-endorsed measures are specified using ICD–9–CM codes.

To prepare for this major transition, NQF examined the implications for its measure maintenance procedures and analyzed the impact of code transitions for the measurement community, particularly measure developers, as the healthcare field begins to shape processes to accommodate the necessary measure updates. In October 2010, NQF published a report, *ICD–10–CM/PCS Coding Maintenance Operational Guidance,* detailing a series of recommendations to assist measure developers and NQF in this transition to ICD–10.

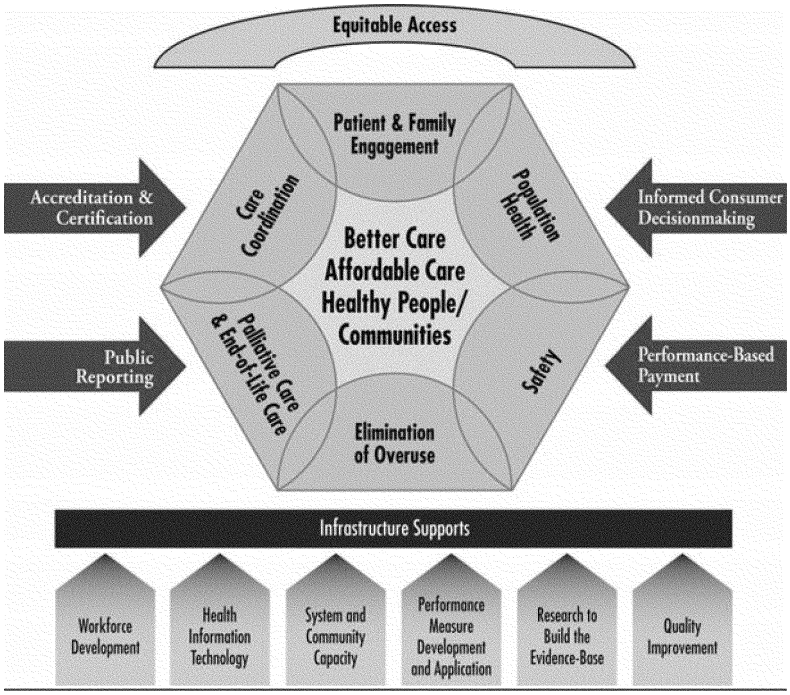
Emergency Regionalization

Regionalizing emergency medical care services—i.e., directing patients to emergency facilities with optimal capabilities for a given type of illness or injury in order to coordinate emergency care across a region—is one policy option for improving care while making more efficient use of medical resources. Under the HHS contract, NQF has undertaken a project to identify quality measures already in place and identify gaps in the measurement of regionalized emergency medical care services that must be filled if one is to provide a detailed picture of the utilization and quality of emergency services at the national, state, and regional levels. The first phase of this work, conducting an environmental scan of existing projects and performance measures and developing a framework to guide measure development and identify gaps as well as points of leverage for regionalization of emergency medical services, was begun in late 2010 and is expected to be completed in early 2012.

Recommendations on the National Quality Strategy (Task 13)

The Affordable Care Act, which became law March 23, 2010, calls for HHS to establish a National Health Care Quality Strategy that will integrate multiple public- and private-sector quality improvement initiatives. This strategy will ultimately include a comprehensive strategic plan and the identification of priorities to improve the delivery of healthcare services, patient health outcomes, and population health. In September 2010, the HHS–NQF contract was modified to comply with Section 3014 of the Affordable Care Act, which requires the Secretary of HHS to consult with a consensus-based entity to convene a multi-stakeholder group to provide input on national priorities for improvement in population health and in the delivery of health care services for consideration under the National Quality Strategy. NQF convened the National Priorities Partnership to accomplish this project, which became Task 13 under the HHS contract.

In October 2010, the NPP submitted its report to HHS, identifying eight priority areas for national action. These include the original six priorities that the NPP identified in 2008—patient and family engagement, population health, safety, care coordination, palliative and end-of-life care, and overuse—and the addition of two areas of focus: Equitable access to ensure that all patients have access to affordable, timely, and high-quality care; and infrastructure supports (*e.g.,* health IT) to address underlying system changes that will be necessary to attain the goals of the other priority areas. NPP also offered aspirational and actionable goals to be achieved over the next three to five years for each priority area.



Notes

1. NQF, *Prioritization of High-Impact Medicare Conditions and Measure Gaps,* Washington, DC: NQF; 2010.

2. The list of the top 20 high-impact Medicare conditions was provided to NQF by HHS, as those conditions that account for 95 percent of Medicare costs based on an analysis of claims in CMS's *Chronic Conditions Warehouse.* Available at *http://ccwdata.org/.* Last accessed January 2011.

3. NQF, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report,* Washington, DC: NQF; 2006.

4. NQF, *National Voluntary Consensus Standards for Nursing Home Care: A Consensus Report,* Washington, DC: NQF; 2004.

5. NQF's Measure Evaluation Criteria can be found at *http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx.* Last accessed December 2010.

6. US Government Accountability Office (GAO), *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices,* Washington, DC: GPO; 2008. Available at *http://www.gao.gov/new.items/d08452.pdf.* Last accessed January 2011.

V. Looking Forward

It now has been just over two years since NQF began its work with HHS under the contract following the Medicare Improvements for Patients and Providers Act. This contract has led to specific, measurable results.

Accomplishments have included:

- The presentation of multi-stakeholder input on the Secretary's National Quality Strategy, with the foundation being laid for a strong public-private partnership focused on achieving the aims of that strategy;
- The endorsement of performance measures in key gap areas, including measures of care transitions for acute myocardial infarction, heart failure, and pneumonia; inpatient psychiatric hospital measures; and measures addressing population health and care coordination; and
- The migration of performance measures to an electronic platform and the development of a process by which measures can be more easily adapted to an electronic format.

Much work remains to be done on these and other initiatives central to improving the quality of American healthcare. But the work performed in the past two years comprises an important foundation upon which the nation's healthcare quality enterprise can continue to build.

In 2011, NQF will continue to convene multiple stakeholders to provide input to HHS on its priority- and goal-setting efforts, endorse and maintain an even greater number of performance measures, and facilitate the integration of performance measurement into electronic health records. Additionally, NQF is just beginning to implement work called for under the Affordable Care Act. This will be centered on the establishment of the Measure Applications Partnership, a multi-stakeholder group that will provide input to the HHS Secretary on the selection of quality measures for public reporting and payment programs.

The nation's quality infrastructure, of which NQF is a part, is still being built—but its foundations are strong. NQF remains committed to working with HHS and its agencies to refashion the American healthcare system into one that is, as the IOM envisioned, safe, timely, effective, efficient, equitable, and patient centered.

Appendix A: Summary of Accomplishments Under the Contract: Jan. 14, 2010, to Jan. 13, 2011

Task	Description	Output	Status (as of 01/13/11)	Notes
6 National Strategy and Priorities				

Task	Description	Output	Status (as of 01/13/11)	Notes
6.0	Prioritization of Medicare high-impact conditions.	Report with list of 20 high-impact conditions, prioritized.	Completed May 2010	*Prioritization of High-Impact Medicare Conditions and Measure Gaps http://www.qualityforum.org/projects/prioritization.aspx#t=2&s=&p=4%7C.*
6.1	Analysis of uses of NQF-endorsed measures.	Work plan and list of research questions completed; report pending.	In progress	Project delayed to address issues of intellectual property and ability of proposed subcontractor to publish under HHS contract.
6.2	Measure development and endorsement agenda.	Report setting agenda for measure development and endorsement.	Completed January 2011.	*Measure Development and Endorsement Agenda http://www.qualityforum.org/MeasureDevelopmentandEndorsementAgenda.aspx#t=2&s=&p=4%7C.*
6.3	Analysis of measures being used to gauge quality of care for people with multiple chronic conditions.	Work plan completed	In progress	Project delayed to address issues of intellectual property and ability of proposed subcontractor to publish under HHS contract.
6.4	Analysis of potential ''Meaningful Use'' measures.	Report proposing a framework and criteria for selection of 2013 MU measures; and identification of available measures.	Completed July 2010	*Identification of Potential 2013 e-Quality Measures http://www.qualityforum.org/projects/i-m/meaningful_use/meaningful_use.aspx.*
7 Implementation				
7.1	Patient outcomes	Three-phase project endorsing measures specific to outcomes on Medicare high-impact conditions, child health, and mental health.	In progress	Eight measures endorsed during contract year (an additional 27 measures subsequently endorsed in January 2011 after close of reporting period).
7.2	*Care coordination*	*N/A*	*N/A*	*Project moved at HHS request to 2011, to be funded by the Affordable Care Act.*
7.3	Patient safety: Serious Reportable Events (SREs).	Reviewing existing list of SREs for hospitals to identify ones appropriate for other settings; considering potential new SREs for all settings.	In progress	Updated SRE list applicable to new environments of care expected Spring 2011.
7.3	Patient safety: Measures	Two-phase project endorsed new measures of patient safety (*e.g.,* healthcare associated infections, medication safety) and maintaining currently endorsed measures.	In progress	Measures from Phase 1 expected Spring 2011; measures from Phase 2 expected Summer 2011.
7.3	Patient safety: Guidance for publicly reporting safety information.	Report providing public reporting guidance.	Completed September 2010.	*National Voluntary Consensus Standards for Public Reporting of Patient Safety Event Information http://www.qualityforum.org/Projects/Safety_Reporting_Framework/Framework.aspx#t=2&s=&p=5%7C.*
7.3	Patient safety: State-based reporting agencies initiative.	Convened 27 state-based patient safety reporting agencies to discuss safety reporting efforts and share ''best practices''.	In progress	Final HHS-funded call completed after reporting period (January 24, 2011) per schedule.
7.4	Palliative care	Endorsed measures of palliative care quality.	In progress	Endorsed measures expected November 2011.
7.5	Nursing homes	Endorsed measures of nursing home care quality.	In progress	Project completed and five measures endorsed in February 2011 after close of contract year.
7.6	Evaluation of NQF endorsement process.	Report analyzing NQF Endorsement Process.	Completed January 2011.	*Assessment of the National Quality Forum's Consensus Development Process* (Mathematica Policy Research, Inc.) *http://www.qualityforum.org/Measuring_Performance/Improving_NQF_Process/Improving_NQF_S_Processes.aspx.*
7.8	Child health measures ..	Endorsed measures specific to the care of children.	In progress	Endorsed measures expected Summer 2011.
8 Measure Maintenance				

Task	Description	Output	Status (as of 01/13/11)	Notes
	NQF measure endorsement and maintenance: process and schedule.	Created systematized process and schedule for maintaining all NQF-endorsed measures over three-year period.	Completed August 2011	
	Cardiovascular measure maintenance.	Two-phase project to endorse new cardiovascular measures and conduct maintenance on existing ones.	In progress	Endorsed measures from Phase 1 anticipated November 2011, from Phase 2 anticipated January 2012.
	Surgery measures maintenance.	Two-phase project to maintain NQF-endorsed surgery measures and consider new ones.	In progress	Endorsed measures from Phase 1 anticipated November 2011; from Phase 2 anticipated January 2012.
9 Health Information Technology				
9.1	Measure authoring tool	Work with subcontractor to create tool that would allow a measure developer to standardize data elements for writing measures electronically.	In progress	Beta version developed by 01/13/11; beta testing to take place late 2011.
9.2	Clinical Decision Support Project.	Produced report on performance measurement and clinical decision support.	Completed December 2010.	*Driving Quality and Performance Measurement—A Foundation for Clinical Decision Support* released in December 2010 *http://www.qualityforum.org/Publications/2010/12/Driving_Quality_and_Performance_Measurement_-_A_Foundation_for_Clinical_Decision_Support.aspx.*
9.5	Quality Data Model (QDM) Maintenance.	Updated QDM to reflect additional types of data needed to support emerging measures (*e.g.,* measures that include social determinants of health).	Ongoing Fall 2010	Released version 2.1 of QDM in Fall 2010 for public comment *http://www.qualityforum.org/Projects/h/QDS_Model/Quality_Data_Model.aspx#t=2&s=&p=3%7C.*
9.6	Health IT Utilization Project.	Produced report on potential types of measures of health IT use and early detection of unintended consequences.	Completed December 2010.	*Driving Quality—A Health IT Assessment Framework* released in December 2010 *http://www.qualityforum.org/Publications/2010/12/Driving_Quality_-_A_Health_IT_Assessment_Framework_for_Measurement.aspx.*
9.7	Measure retooling for EHRs.	Retooled 113 NQF-endorsed measures for use in EHRs.	Completed December 2010.	Measures and eSpecifications have been posted on NQF website for public comment and can be found at *http://www.qualityforum.org/Projects/e-g/eMeasure_Format_Review/eMeasure_Format_Review.aspx#t=2&s=&p=4%7C.*
9.8	eMeasure Format Review Panel.	Convened panel to review retooled measures from Task 9.7 to ensure the eSpecifications of these measures is consistent with the original focus and intent of the measure.	Ongoing	Completed first cycle of review in Fall 2010, following public comment period.
11 Website				
	Public-facing Web site ...	Update and enhance NQF Web site to support and enable projects funded under this contract.	Ongoing	Added online measure submission form included adapted versions for efficiency measures, new public commenting tool, and improved online voting platform.
12 Measurement Development, Harmonization, and Endorsement				

Task	Description	Output	Status (as of 01/13/11)	Notes
12.1	Efficiency and resource use.	Endorsed measures of imaging efficiency; white paper drafted; endorsed measures of healthcare efficiency.	In progress	Six imaging efficiency measures endorsed February 2011; one imaging efficiency measure was recommended to be combined with an existing NQF measure. White paper being redrafted to respond to comments. Healthcare efficiency resource use measures endorsement project delayed to allow time for developers to complete measures and to better coordinate with related work in HHS, but now underway.
12.2	Harmonization	Report with guidance for measure developers on how to approach harmonization of quality measures across settings and patient populations.	Completed December 2010.	*Guidance for Measure Harmonization* in press.
12.3	ICD–10 conversion guidance.	Report on how to convert from ICD–9 to ICD–10.	Completed September 2011.	*ICD–10–CM/PCS Coding Maintenance Operational Guidance: A Consensus Report http://www.qualityforum.org/Publications/2010/10/ICD–10–CM/PCS_Coding_Maintenance_Operational_Guidance.aspx.*
12.5	Emergency regionalization.	Environmental scan and white paper comparing how regions coordinate and perform on delivering emergency services.	In progress	Final report expected November 2011.
13 National Quality Strategy: Priorities				
	Input on priorities for the National Strategy for Quality Improvement.	Report to the Secretary of HHS with recommendations on priorities and goals for the proposed National Quality Strategy.	Completed October 2010.	*Input to the Secretary of Health and Human Services on Priorities for the 2011 National Quality Strategy http://www.nationalprioritiespartnership.org/.*

Appendix B: List of Measures Endorsed

Includes 62 newly endorsed resulting from the work conducted during the contract period, 14 endorsed prior to the close of the contract period, and another 48 awaiting final ratification by the NQF Board of Directors (which occurred shortly after the close of the contract period).

Measure No.	Measure name	Care setting(s)	Subject/topic area (*e.g.*, condition, setting, cross-cutting area)	Status as of 01/13/2011
OT2–002–09	Risk adjusted colorectal surgery outcome measure.	Hospital	Surgery	Awaiting Board ratification (endorsed 1/17/11).
OT1–008–09	Hospital 30-day risk-standardized readmission rates following percutaneous coronary intervention (PCI).	Hospital	Cardiovascular	Endorsed.
OT1–015–09	Risk adjusted case mix adjusted elderly surgery outcomes measure.	Hospital	Cross-cutting/Surgery	Awaiting Board ratification (endorsed 1/17/11).
OT1–007–09	Hospital risk-standardized complication rate following implantation of implantable cardioverter-defibrillator (ICD).	Hospital	Cardiovascular	Endorsed.
OT1–020–09	Functional capacity in COPD patients before and after pulmonary rehabilitation.	Other	Respiratory/ICU	Endorsed.
OT1–019–09	Health-related quality of life in COPD patients before and after pulmonary rehabilitation.	Other	Respiratory/ICU	Endorsed.
OT1–024–09	Intensive care: in-hospital mortality rate.	Hospital	Respiratory/ICU	Endorsed.

Measure No.	Measure name	Care setting(s)	Subject/topic area (*e.g.*, condition, setting, cross-cutting area)	Status as of 01/13/2011
OT1–023–09	Intensive Care Unit (ICU) length-of-stay (LOS).	Hospital	Respiratory/ICU	Endorsed.
OT1–031–09	Proportion of patients hospitalized with stroke that have a potentially avoidable complication (during the index stay or in the 30-day post-discharge period).	Hospital	Neurology (Stroke)	Awaiting Board ratification (endorsed 1/17/11).
OT1–030–09	Proportion of patients hospitalized with AMI that have a potentially avoidable complication (during the index stay or in the 30-day post-discharge period).	Hospital	Cardiovascular	Awaiting Board ratification (endorsed 1/17/11).
OT2–013–09	Proportion of patients hospitalized with pneumonia that have a potentially avoidable complication (during the index stay or in the 30-day post-discharge period).	Hospital	Respiratory/ICU	Awaiting Board ratification (endorsed 1/17/11).
OT1–013–09	The STS CABG composite score.	Hospital	Surgery	Awaiting Board ratification (endorsed 1/17/11).
OT1–016–09	30-Day post-hospital AMI discharge care transition composite measure.	Hospital	Cardiovascular	Endorsed.
OT1–017–09	30-Day post-hospital HF discharge care transition composite measure.	Hospital	Cardiovascular	Endorsed.
OT2–005–09	30-Day post-hospital pneumonia discharge care transition composite measure.	Hospital	Respiratory/ICU	Awaiting Board ratification (endorsed 1/17/11).
OT2–022–09	Proportion of patients with chronic conditions that have a potentially avoidable complication during the calendar year.	Health Plan; Group; Population.	Cross-cutting	Awaiting Board ratification (endorsed 1/17/11).
OT3–057–10	Asthma admission rate	Other	Outcomes/child health: asthma.	Awaiting Board ratification (endorsed 1/17/11).
OT3–055–10	Gastroenteritis admission rate (pediatric).	Hospital	Outcomes/child health	Awaiting Board ratification (endorsed 1/17/11).
OT3–046–10	Validated family-centered survey questionnaire for parents' and patients' experiences during inpatient pediatric hospital stay.	Hospital	Outcomes/child health: survey, patient experience of care.	Awaiting Board ratification (endorsed 1/17/11).
OT3–045–10	Measure of medical home for children and adolescents.	Other	Outcomes/child health: access to care.	Awaiting Board ratification (endorsed 1/17/11).
OT3–044–10	Children who have inadequate insurance coverage for optimal health.	Other	Outcomes/child health: access to care.	Awaiting Board ratification (endorsed 1/17/11).
OT3–043–10	Pediatric symptom checklist (PSC).	All settings	Outcomes/child health: survey.	Awaiting Board ratification (endorsed 1/17/11).
OT3–041–10	Children who attend schools perceived as safe.	Other	Outcomes/child health: survey.	Awaiting Board ratification (endorsed 1/17/11).
OT3–039–10	Children who live in communities perceived as safe.	Other	Outcomes/child health: survey.	Awaiting Board ratification (endorsed 1/17/11).
OT3–038–10	Children who receive effective care coordination of healthcare services when needed.	Other	Outcomes/child health: access to care.	Awaiting Board ratification (endorsed 1/17/11).
OT3–036–10	Children who had problems obtaining referrals when needed.	Other	Outcomes/child health: access to care.	Awaiting Board ratification (endorsed 1/17/11).
OT3–032–10	Number of school days children miss due to illness.	Other	Outcomes/child health: survey.	Awaiting Board ratification (endorsed 1/17/11).
OT3–031–10	Healthy term newborn	Hospital	Outcomes/child health: perinatal.	Awaiting Board ratification (endorsed 1/17/11).

Measure No.	Measure name	Care setting(s)	Subject/topic area (*e.g.*, condition, setting, cross-cutting area)	Status as of 01/13/2011
OT3–029–10	Standardized adverse event ratio for children and adults undergoing cardiac catheterization for congenital heart disease.	Hospital	Outcomes/child health: cardiology.	Awaiting Board ratification (endorsed 1/17/11).
OT3–028–10	Standardized mortality ratio for neonates undergoing non-cardiac surgery.	Hospital	Outcomes/child health: mortality.	Awaiting Board ratification (endorsed 1/17/11).
OT3–027–10	Ventriculoperitoneal (VP) shunt malfunction rate in children.	Hospital	Outcomes/child health	Awaiting Board ratification (endorsed 1/17/11).
OT3–011–10	Depression remission at twelve months.	Ambulatory care: office, clinic, behavioral health/psychiatric unit.	Mental health/depression	Awaiting Board ratification (endorsed 1/17/11).
OT3–012–10	Depression remission at six months.	Ambulatory care: office, clinic, behavioral health/psychiatric unit.	Mental health/depression	Awaiting Board ratification (endorsed 1/17/11).
OT3–022–10	Depression utilization of the PHQ–9 tool.	Ambulatory care: office, clinic, behavioral health/psychiatric unit.	Mental health/depression	Awaiting Board ratification (endorsed 1/17/11).
OT3–047–10	Inpatient consumer survey	Hospital, long-term acute care hospital, behavioral health/psychiatric unit.	Mental health/patient experience.	Awaiting Board ratification (endorsed 1/17/11).
NH–003–10	Physical therapy or nursing rehabilitation/restorative care for long-stay patients with new balance problem.	Nursing home/skilled nursing facility.	Nursing homes/falls	Awaiting Board ratification (endorsed 2/28/11).
NH–008–10	Percent of residents experiencing one or more falls with major injury (long stay).	Nursing home/skilled nursing facility.	Nursing homes/falls	Awaiting Board ratification (endorsed 2/28/11).
NH–009–10	The percentage of residents on a scheduled pain medication regimen on admission who report a decrease in pain intensity or frequency (short stay).	Nursing home/skilled nursing facility.	Nursing homes/pain	Awaiting Board ratification (endorsed 2/28/11).
NH–010–10	Percent of residents who self-report moderate to severe pain (short stay).	Nursing home/skilled nursing facility.	Nursing homes/pain	Awaiting Board ratification (endorsed 2/28/11).
NH–011–10	Percent of residents who self-report moderate to severe pain (long stay).	Nursing home/skilled nursing facility.	Nursing homes/pain	Awaiting Board ratification (endorsed 2/28/11).
NH–012–10	Percent of residents with pressure ulcers that are new or worsened (short stay).	Nursing home/skilled nursing facility.	Nursing homes/pressure ulcers.	Awaiting Board ratification (time-limited).
NH–013–10	Percent of high-risk residents with pressure ulcers (long stay).	Nursing home/skilled nursing facility.	Nursing homes/pressure ulcers.	Awaiting Board ratification (endorsed 2/28/11).
NH–014–10	Percent of residents who were assessed and appropriately given the seasonal influenza vaccine during the flu season (short stay).	Nursing home/skilled nursing facility.	Nursing homes/immunization	Awaiting Board ratification (endorsed 2/28/11).
NH–015–10	Percent of residents who were assessed and appropriately given the seasonal influenza vaccine (long stay).	Nursing home/skilled nursing facility.	Nursing homes/immunization	Awaiting Board ratification (endorsed 2/28/11).
NH–016–10	Percent of residents who were assessed and appropriately given the pneumococcal vaccine (short stay).	Nursing home/skilled nursing facility.	Nursing homes/immunization	Awaiting Board ratification (endorsed 2/28/11).
NH–017–10	Percent of residents who were assessed and appropriately given the pneumococcal vaccine (long stay).	Nursing home/skilled nursing facility.	Nursing homes/immunization	Awaiting Board ratification (endorsed 2/28/11).
NH–018–10	Percent of residents with a urinary tract infection (long stay).	Nursing home/skilled nursing facility.	Nursing homes/functionality ..	Awaiting Board ratification (endorsed 2/28/11).

Measure No.	Measure name	Care setting(s)	Subject/topic area (*e.g.*, condition, setting, cross-cutting area)	Status as of 01/13/2011
NH–019–10	Percent of low-risk residents who lose control of their bowels or bladder (long stay).	Nursing home/skilled nursing facility.	Nursing homes/functional status.	Awaiting Board ratification (endorsed 2/28/11).
NH–020–10	Percent of residents who have/had a catheter inserted and left in their bladder (long stay).	Nursing home/skilled nursing facility.	Nursing homes/safety	Awaiting Board ratification (endorsed 2/28/11).
NH–021–10	Percent of residents who were physically restrained (long stay).	Nursing home/skilled nursing facility.	Nursing homes/safety	Awaiting Board ratification (endorsed 2/28/11).
NH–022–10	Percent of residents whose need for help with daily activities has increased (long stay).	Nursing home/skilled nursing facility.	Nursing homes/functionality ..	Awaiting Board ratification (endorsed 2/28/11).
NH–024–10	Percent of residents who lose too much weight (long stay).	Nursing home/skilled nursing facility.	Nursing homes/functionality ..	Awaiting Board ratification (endorsed 2/28/11).
NH–025–10	Percent of residents who have depressive symptoms (long stay).	Nursing home/skilled nursing facility.	Nursing homes/mental health	Awaiting Board ratification (endorsed 2/28/11).
NH–026–10	Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Discharged Resident Instrument.	Nursing home/skilled nursing facility.	Nursing homes/patient experience.	Awaiting Board ratification (endorsed 2/28/11).
NH–027–10	Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Long-Stay Resident Instrument.	Nursing home/skilled nursing facility.	Nursing homes/patient experience.	Awaiting Board ratification (endorsed 2/28/11).
NH–028–10	Consumer Assessment of Health Providers and Systems (CAHPS®) Nursing Home Survey: Family Member Instrument.	Nursing home/skilled nursing facility.	Nursing homes/patient experience.	Awaiting Board ratification (endorsed 2/28/11).
IEP–005–10	Pulmonary CT imaging for patients at low risk for pulmonary embolism.	Ambulatory care: ED could consider for additional ambulatory settings: office, clinic and hospital outpatient.	Overuse/safety	Endorsed.
IEP–007–10	Appropriate head CT imaging in adults with mild traumatic brain injury.	Ambulatory care: ED could consider for additional ambulatory settings: office, clinic and hospital outpatient.	Overuse/safety	Endorsed.
IEP–010–10	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery.	Ambulatory care: hospital outpatient.	Overuse/safety	Endorsed.
IEP–014–10	Cardiac stress imaging not meeting appropriate use criteria: preoperative evaluation in low risk surgery patients.	Ambulatory care: hospital outpatient, office.	Overuse/safety	Endorsed.
IEP–015–10	Cardiac stress imaging not meeting appropriate use criteria: routine testing after percutaneous coronary interventions (PCI).	Ambulatory care: hospital outpatient, office.	Overuse/safety	Endorsed.
IEP–016–10	Cardiac stress imaging not meeting appropriate use criteria: testing in asymptomatic, low-risk patients.	Ambulatory care: hospital outpatient, office.	Overuse/safety	Endorsed.

Appendix C: Reports Published by NQF Under the HHS Contract Between January 14, 2010, and January 13, 2011

Prioritization of High-Impact Medicare Conditions and Measure Gaps; Task 6.0; May 2010 *http://www.qualityforum.org/projects/prioritization.aspx#t=2&s=p-4%7C.*

Measure Development and Endorsement Agenda; Task 6.2; January 2011 *http://www.qualityforum.org/MeasureDevelopmentandEndorsementAgenda.aspx.*

Identification of Potential 2013 e-Quality Measures; Task 6.4; August 2010 *http://www.qualityforum.org/projects/i-m/meaningful_use/meaningful_use.aspx.*

National Voluntary Consensus Standards for Public Reporting of Patient Safety Event Information; Task 7.3; September 2010 *http://www.qualityforum.org/Projects/Safety_Reporting_Framework/Framework.aspx#t=2&s=&p=5%7C.*

Assessment of the National Quality Forum's Consensus Development Process (Mathematica Policy Research, Inc.); Task 7.6; December 2010 *http://www.qualityforum.org/Measuring_Performance/Improving_NQF_Process/Improving_NQF_S_Processes.aspx.*

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Input to the Secretary of Health and Human Services on Priorities for the 2011 National Quality Strategy; Task 13; October 2010 *http://www.nationalprioritiespartnership.org.*

Appendix D: NQF Board of Directors

William L. Roper, MD, MPH (Chair), Dean, School of Medicine, Vice Chancellor for Medical Affairs and Chief Executive Officer, UNC Health Care System, University of North Carolina at Chapel Hill.

Andrew Webber (Vice Chair), President and CEO, National Business Coalition on Health.

Gerald M. Shea (Treasurer), Assistant to the President for External Affairs, AFL–CIO.

Richard J. Baron, MD, FACP, President and Founder, Greenhouse Internists.

Lawrence M. Becker, Director, HR Strategic Partnerships, Xerox Corporation.

JudyAnn Bigby, MD, Secretary, Executive Office of Health & Human Services, Commonwealth of Massachusetts.

Janet M. Corrigan, PhD, MBA, President and CEO, National Quality Forum.

Maureen Corry, Executive Director, Childbirth Connection.

Helen Darling, MA, President, National Business Group on Health.

Robert Galvin, MD, MBA, Chief Executive Officer, Equity Healthcare, The Blackstone Group.

Wade Henderson, *Esq.,* President and CEO, Leadership Conference on Civil Rights.

Ardis Dee Hoven, MD, Chair, American Medical Association Board of Trustees and Medical Director, Bluegrass Care Clinic, Affiliated with the University of Kentucky School of Medicine.

Karen Ignagni, MBA, President and CEO, America's Health Insurance Plans (AHIP).

Chris Jennings, President, Jennings Policy Strategies, Inc.

Charles N. Kahn III, MPH, President, Federation of American Hospitals.

Mark B. McClellan, MD, PhD, Senior Fellow and Director, Engelberg Center for Health Care Reform and Leonard D. Schaeffer Chair in Health Policy Studies, The Brookings Institution.

Sheri S. McCoy, Worldwide Chairman of the Pharmaceuticals Group, Johnson & Johnson.

Harold D. Miller, President and CEO, Network for Regional Healthcare Improvement.

Dolores L. Mitchell, Executive Director, Commonwealth of Massachusetts Group Insurance Commission.

Mary Naylor, PhD, RN, FAAN, Director, New Courtland Center for Transitions & Health and Marian S. Ware Professor in Gerontology, University of Pennsylvania School of Nursing.

Debra L. Ness, President, National Partnership for Women & Families.

Samuel R. Nussbaum, MD, Executive Vice President and Chief Medical Officer, WellPoint, Inc.

J. Marc Overhage, MD, PhD, Director, Regenstrief Institute and President and CEO, Health Information Exchange.

John C. Rother, JD, Executive Vice President for Policy and Strategy, AARP.

Bernard M. Rosof, MD, Chair, Board of Directors, Huntington Hospital and Chair, Physician Consortium for Performance Improvement convened by the American Medical Association.

Joseph R. Swedish, FACHE, President and CEO, Trinity Health.

John Tooker, MD, MBA, FACP, Associate Executive Vice President, American College of Physicians.

Richard J. Umbdenstock, President and CEO, American Hospital Association.

CMS

Donald M. Berwick, Administrator.

Designee: Barry Straube, MD, Chief Medical Officer and Director, Office of Clinical Standards and Quality.

AHRQ

Carolyn M. Clancy, MD, Director.

NIH

Francis S. Collins, MD, PhD, Director, National Institutes of Health.

Designee: Barry Portnoy, PhD, Senior Advisor for Disease Prevention.

HRSA

Mary Wakefield, PhD, RN, Administrator.

Designee: Kyu Rhee, MD.

CDC

Thomas R. Frieden, MD, MPH, Director.

Designee: Peter A. Briss, MD, MPH, Captain, U.S. Public Health Service, Medical Director.

Ex Officio (Non-Voting)

Arthur Levin, MPH, (Chair, Consensus Standards Approval Committee), Director, Center for Medical Consumers.

Curt Selquist, (Chair, Leadership Network), Johnson & Johnson Health Care System, Inc. (retired).

Paul C. Tang, MD, MS, Vice President and Chief Medical Information Officer, Palo Alto Medical Foundation and Chair, Health Information Technology Advisory Committee.

Appendix E: NQF Senior Leadership

Janet M. Corrigan, President and Chief Executive Officer.

Karen Adams, Vice President, National Priorities.

Helen Burstin, Senior Vice President, Performance Measures.

Floyd Eisenberg, Senior Vice President, Health Information Technology.

Marybeth Farquhar, Vice President for Performance Measures.

Larry Gorban, Vice President, Operations.

Ann Hammersmith, General Counsel.

Lisa Hines, Vice President, Member Services and Education.

Laura Miller, Senior Vice President and Chief Operating Officer.

Nicole Silverman, Vice President, Federal Program Management.

Mary Shaffran, Vice President, Health Information Technology.

Diane Stollenwerk, Vice President, Community Alliances.

Thomas Valuck, Senior Vice President, Strategic Partnerships.

Kyle Vickers, Chief Information Officer.

Appendix F: National Priorities Partnership

National Committee for Quality Assurance

(Margaret E. O'Kane, MHS, President; NPP Co-Chair)

Physician Consortium for Performance Improvement Convened by the American Medical Association

(Bernard Rosof, MD, Chair; NPP Co-Chair)

AARP
AFL–CIO
Aligning Forces for Quality
Alliance for Home Health Quality and Innovation
Alliance for Pediatric Quality
America's Health Insurance Plans
American Board of Medical Specialties
American Health Care Association
American Medical Informatics Association
American Medical Association
American Nurses Association
AQA
Association of State and Territorial Health Officials
Certification Commission for Health Information Technology
Consumers Union
Hospital Quality Alliance
Institute for Healthcare Improvement
Institute of Medicine
Johnson & Johnson Health Care Systems
The Joint Commission
Leapfrog Group
National Association of Community Health Centers
National Association of Medicaid Directors
National Business Group on Health
National Governors Association
National Hispanic Medical Association
National Initiative for Children's Healthcare Quality
National Partnership for Women & Families
National Quality Forum
Network for Regional Healthcare
Nursing Alliance for Quality Care
Pacific Business Group on Health
Partnership for Prevention
Patient Centered Primary Care Collaborative
Pharmacy Quality Alliance
Planetree
Quality Alliance Steering Committee
U.S. Chamber of Commerce

Ex-Officio Partner Organizations

Agency for Healthcare Research and Quality
Centers for Disease Control and Prevention
Centers for Medicare & Medicaid Services
Health Resources and Services Administration
National Institutes of Health
Veterans Health Administration

Appendix G: NQF Consensus Development Process (Version 1.8)

NQF uses its formal Consensus Development Process (CDP) to evaluate and endorse consensus standards, including performance measures, best practices, frameworks, and reporting guidelines. The CDP is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry.

Because NQF uses this formal CDP, it is recognized as a voluntary consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of 1995 [1] and Office of Management and Budget Circular A–119.[2] Over the past 10 years, the procedures that form NQF's CDP and its implementation have evolved to ensure that evaluation of candidate consensus standards continues to follow best practices in performance measurement and standards-setting. NQF is currently using version 1.8 of the CDP.

NQF's CDP involves nine principal steps. Each contains several substeps and is associated with specific actions. The steps are:

1. Call for Intent to Submit Candidate Standards
2. Call for Nominations
3. Call for Candidate Standards
4. Candidate Consensus Standard Review
5. Public and Member Comment
6. Member Voting
7. Consensus Standards Approval Committee (CSAC) Decision
8. Board Ratification
9. Appeals

Notes

1. U.S. Congress, *National Technology Transfer and Advancement Act of 1995 (PL 104–113),* Washington, DC: U.S. Government Printing Office; 1995. Available at *http://standards.gov/standards_gov/nttaa.cfm. Last accessed December 2010.*

2. The White House, *U.S. Office of Management and Budget, Circular No. A–119, February 10, 1998,* Washington, DC: Office of Management and Budget; 1998. Available at *http://www.whitehouse.gov/omb/circulars_a119/.* Last accessed December 2010.

Appendix H: List of NQF Member Organizations by Council

Consumer Council

AARP
AFL–CIO
American Federation of Teachers Healthcare
American Hospice Foundation
American Sleep Apnea Association
Childbirth Connection
Citizens for Patient Safety
Coalition for Improving Maternity Services
Community Catalyst
Community Health Foundation of Western and Central New York
Connecticut Center for Patient Safety
Consumer Coalition for Quality Health Care
Consumers Advancing Patient Safety
Consumers' Checkbook
Consumers Union
DES Action USA
Foundation for Informed Medical Decision Making
Health Watch USA
Lamaze International
Mothers Against Medical Error
National Breast Cancer Coalition
National Coalition for Cancer Survivorship
National Consumers League
National Council on Aging
National Health Law Program
National Partnership for Women & Families
National Sleep Foundation
Patient Centered Primary Care Collaborative
PULSE of New York
The Coordinating Center
The Empowered Patient Coalition
The National Consumer Voice for Quality Long-Term Care
The Partnership for Healthcare Excellence
Trauma Support Network
Trust for America's Health

Health Plan Council

Aetna
Alliance of Community Health Plans
America's Health Insurance Plans
Arkansas Medicaid
BlueCross BlueShield Association
CareFirst BlueCross BlueShield
CIGNA HealthCare
Highmark, Inc.
Horizon Blue Cross Blue Shield of New Jersey
Hudson Health Plan
Humana Inc.
Kaiser Permanente
UnitedHealth Group
Universal American Corp
WellPoint

Health Professionals Council

AANAC
Academy of Managed Care Pharmacy
Academy of Medical-Surgical Nurses

American Academy of Audiology
American Academy of Dermatology
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Nurse Practitioners
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Birth Centers
American Association of Cardiovascular and Pulmonary Rehabilitation
American Association of Clinical Endocrinologists
American Association of Diabetes Educators
American Association of Neurological Surgeons
American Association of Nurse Anesthetists
American Case Management Association
American Chiropractic Association
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American College of Physician Executives
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Dietetic Association
American Gastroenterological Association Institute
American Geriatrics Society
American Health Information Management Association
American Heart Association
American Medical Association
American Medical Directors Association
American Nurses Association
American Optometric Association
American Organization of Nurse Executives
American Osteopathic Association
American Pharmacists Association Foundation
American Physical Therapy Association
American Psychiatric Nurses Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society of Health-System Pharmacists
American Society of Hematology
American Society of Pediatric Nephrology
American Society of Plastic Surgeons
American Urological Association
Association for Professionals in Infection Control and Epidemiology
Association for the Advancement of Wound Care
Association of periOperative Registered Nurses
Association of Rehabilitation Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
Council of Medical Specialty Societies
Heart Rhythm Society
Hospice and Palliative Nurses Association
Infectious Diseases Society of America
Infusion Nurses Society
National Academy of Clinical Biochemistry
National Alliance of Wound Care
National Association for Behavioral Health
National Association of Certified Professional Midwives
National Association of Pediatric Nurse Practitioners
National Nursing Staff Development Organization
National Pressure Ulcer Advisory Panel
New York University College of Nursing
Nursing Alliance for Quality Care
Ohio Hospice & Palliative Care Organization
Renal Physicians Association
Society for Academic Emergency Medicine
Society for Cardiovascular Angiography and Interventions
Society for Healthcare Epidemiology of America
Society for Vascular Surgery
Society of Critical Care Medicine
Society of General Internal Medicine
Society of Hospital Medicine
Society of Thoracic Surgeons
Wisconsin Medical Society
Wound, Ostomy and Continence Nurses Society

Provider Council

Adventist Health System
Advocate Physician Partners
Ambulatory Surgery Foundation
Amedisys
American Health Care Association
American Hospital Association
AmSurg Corp.
Ascension Health
Association for Behavioral Health and Wellness
Association of American Medical Colleges
Atlantic Health
Aultman Health Foundation
Aurora Health Care
Baptist Health South Florida
Baptist Memorial Health Care Corporation
BayCare Health System
Baylor Health Care System
BJC HealthCare
Bon Secours St. Francis Health System
Bronson Healthcare Group, Inc.
California Hospital Association
CaroMont Health
Catholic Health Association of the United States
Catholic Health Initiatives
Catholic Healthcare Partners
Cedars-Sinai Medical Center
Child Health Corporation of America
Children's Hospitals and Clinics of Minnesota
CIMPAR, S.C.
City of Hope
Cleveland Clinic
Connecticut Hospital Association
Crozer-Keystone Health System
Dana-Farber Cancer Institute
Detroit Medical Center
DMAA: The Care Continuum Alliance
Emergency Department Practice Management Association
Englewood Hospital and Medical Center
Exeter Health Resources
Federation of American Hospitals
Florida Hospital
Fox Chase Cancer Center
Genesis HealthCare System
Gentiva Health Services
Good Samaritan Hospital
H. Lee Moffitt Cancer Center and Research Institute Hospital, Inc.
Hackensack University Medical Center
Harborview Medical Center
Health Management Associates, Inc.
Healthcare Leadership Council
HealthPartners
HealthSouth Corporation
Henry Ford Health System
Hoag Hospital
Hospital Corporation of America
Hospital for Special Surgery
Illinois Hospital Association
Interim HealthCare Inc.
Johns Hopkins Health System
LHC Group, Inc.
Long-Term Quality Alliance
MaineGeneral Medical Center
Mayo Clinic
MedStar Health
Memorial Hermann Healthcare System
Memorial Sloan-Kettering Cancer Center
Mercy Medical Center
Meridian Health System
Mission Hospital, Inc.
National Association of Children's Hospitals and Related Institutions
National Association of Psychiatric Health Systems
National Association of Public Hospitals and Health Systems
National Consortium of Breast Centers
National Hospice and Palliative Care Organization
National Rural Health Association
NCH Healthcare System
Nemours Foundation
New Jersey Hospital Association
New York Presbyterian Healthcare System
North Mississippi Medical Center
North Shore-Long Island Jewish Health System
North Texas Specialty Physicians
Northwestern Memorial HealthCare
Norton Healthcare, Inc.
OSUCCC–James Cancer Hospital
Park Nicollet Health Services
Partners HealthCare System, Inc.
Pennsylvania Health Care Association
Piedmont Healthcare
Planetree
Premier, Inc.
Providence Health & Services
Robert Wood Johnson University Hospital-Hamilton
Rockford Health System
Roswell Park Cancer Institute
Rush University Medical Center
Saint Barnabas Health Care System
Saint Francis Hospital and Medical Center
Seattle Cancer Care Alliance
Sharp HealthCare
Sisters of Charity of Leavenworth Health System
Sisters of St. Francis Health Services
Southeast Texas Medical Associates, LLP
Stamford Health System
Summa Health System
Surgical Care Affiliates

Sylvester Comprehensive Cancer Center, University of Miami Hospitals and Clinics
Tampa General Hospital
Tenet Healthcare Corporation
Texas Health Resources
The Alliance for Home Health Quality and Innovation
The Health Alliance of Mid America LLC
The National Forum of ESRD Networks
The University of Kansas Hospital
Thomas Jefferson University Hospital
Trinity Health
UMass Memorial Medical Group, Inc.
United Surgical Partners International
University of California-Davis Medical Group
University of Michigan Hospitals & Health Centers
University of Pennsylvania Health System
University of Texas Southwestern Medical Center
University of Texas-MD Anderson Cancer Center
University of Virginia Health System
US Department of Defense-Health Affairs
UW Health
Vanderbilt University Medical Center
Vanguard Health Management
Veterans Health Administration
VHA, Inc.
Virginia Mason Medical Center
Virtua Health
WellSpan Health
WellStar Health System
Yale New Haven Health System

Public/Community Health Agencies Council

Albuquerque Coalition for Healthcare Quality
Aligning Forces for Quality—South Central Pennsylvania
Alliance for Health
Better Health Greater Cleveland
California Office of Statewide Health Planning and Development
Center for Health Care Quality, Department of Health Policy, George Washington University
Centers for Disease Control and Prevention
Central Indiana Alliance for Health
Community Health Alliance-Humboldt County Del-Norte
Greater Detroit Area Health Council
Health Improvement Collaborative of Greater Cincinnati
Health Resources and Services Administration
Healthy Memphis Common Table
Illinois Department of Public Health
Integrated Healthcare Association
Kansas City Quality Improvement Consortium
Maine Quality Forum
Maryland Health Care Commission
Massachusetts Health Quality Partners
Middlesex Hospital
Minnesota Community Measurement
National Academy for State Health Policy
National Association of Health Data Organizations
Oregon Health Care Quality Corporation
P2 Collaborative of Western New York
Puget Sound Health Alliance
Quality Counts
Rhode Island Department of Health
State Associations of Addiction Services
Substance Abuse and Mental Health Services Administration
The HOPE of Wisconsin
Washington State Department of Health
Wisconsin Collaborative for Healthcare Quality

Purchaser Council

Buyers Health Care Action Group
Caterpillar Inc.
Centers for Medicare & Medicaid Services
Colorado Business Group on Health
Employers' Coalition on Health
Florida Health Care Coalition
General Motors Corporation
Health Action Council Ohio
Health Services Coalition
HealthCare 21 Business Coalition
Lehigh Valley Business Coalition on Health Care
Maine Health Management Coalition
Microsoft Corporation
National Association of State Medicaid Directors
National Business Coalition on Health
National Business Group on Health
New Jersey Health Care Quality Institute
Niagara Health Quality Coalition
Pacific Business Group on Health
St. Louis Area Business Health Coalition
The Alliance
The Leapfrog Group
Virginia Business Coalition on Health
Washington State Health Care Authority

QMRI Council

AAAHC Institute for Quality Improvement
ABIM Foundation
ACC/AHA Task Force on Performance Measures
ACS–MIDAS+
Agency for Healthcare Research and Quality
American Academy of Nursing
American Association of Colleges of Nursing
American Board of Medical Specialties
American Board of Optometry
American College of Medical Quality
American Data Network
American Health Quality Association
American Medical Association-Physician Consortium for Performance Improvement
American Medical Informatics Association
American Psychiatric Association for Research and Education
Anesthesia Quality Institute
AYR Consulting Group
Betsy Lehman Center for Patient Safety and Medical Error Reduction
BoozAllenHamilton
California HealthCare Foundation
California Maternal Quality Care Collaborative
Case Management Society of America
Center to Advance Palliative Care
Community Health Accreditation Program
Coral Initiative, LLC
Core Consulting, Inc.
Dallas-Fort Worth Hospital Council Education and Research Foundation
Freedman HealthCare, LLC
Health Level Seven, Inc
Health Services Advisory Group
Healthcare Information and Management Systems Society
HealthGrades
Institute for Clinical Systems Improvement
Institute for Safe Medication Practices
Iowa Foundation for Medical Care
Iowa Healthcare Collaborative
IPRO
Jefferson Health System, Office of Health Policy and Clinical Outcomes
Kidney Care Partners
Louisiana Health Care Quality Forum
Medisolv, Inc.
MHA Keystone Center for Patient Safety & Quality
Milliman Care Guidelines
National Association for Healthcare Quality
National Center for Healthcare Leadership
National Committee for Quality Assurance
National Consensus Project for Quality Palliative Care
National Council of State Boards of Nursing
National Institute for Quality Improvement and Education
National Institutes of Health
National Patient Safety Foundation
Neocure Group
Next Wave
North Carolina Center for Hospital Quality and Patient Safety
Northeast Health Care Quality Foundation
Partnership for Prevention
Pharmacy Quality Alliance
Press Ganey Associates
Professional Research Consultants, Inc.
Quality Indicator Project
Quality Outcomes, LLC
Resolution Health, Inc.
Texas Medical Institute of Technology
The Commonwealth Fund
The Joint Commission
Thomson Reuters
University HealthSystem Consortium
University of Kansas School of Nursing
University of North Carolina-Program on Health Outcomes
URAC
Verilogue, Inc
Virginia Cardiac Surgery Quality Initiative
West Virginia Medical Institute

Supplier/Industry Council

Abbott Laboratories
AMGEN Inc.
Arrowsight, Inc.
AstraZeneca
Boehringer Ingelheim
Bristol-Myers Squibb Company
CareFusion
Deloitte Consulting LLP, Health Sciences and Government
Dialog Medical
Edwards Lifesciences
eHealth Initiative
Eisai, Inc.
Eli Lilly and Company
Elsevier Clinical Decision Support
Epstein Becker & Green, P.C.
GE Healthcare
GlaxoSmithKline
Greenway Medical Technologies
Hospira
MedAssets
MedeAnalytics, Inc.
Merck & Co., Inc
Noblis
Ortho-McNeill-Janssen Pharmaceutical, Inc.
Pfizer
PhRMA
Phytel, Inc.
sanofi pasteur
sanofi-aventis

Siemens Healthcare, USA
The Advanced Medical Technology Association (AdvaMed)
Zynx Health

Acknowledgments

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IV. Secretarial Comments on the Annual Report to Congress

The Secretary is pleased with the scope and vision of NQF's March 2011 annual report to Congress (the ''annual report''). An internal multidisciplinary HHS team is working collaboratively with NQF to provide a clear multi-year vision to ensure the most efficient and effective utilization of the HHS contract. The contract with NQF provides a unique opportunity to further enhance HHS' efforts to foster a collaborative, multi-stakeholder approach to increase the availability of national voluntary consensus standards for quality and efficiency measures that can help to ensure broad transparency in achieving value in health care delivery.

Over the past year NQF continued work on tasks outlined in the Statement of Work, including: development of a national strategy for performance measurement and prioritization of measures for development and endorsement; evaluation of NQF's consensus development process; conduct of measure endorsement projects focused on areas where there are gaps in measures, such as outcomes measures and patient safety measures; maintenance of current NQF-endorsed measures; and promotion of Electronic Health Records through such activities as developing a measure authoring software tool, initiation of a taxonomy and rules for clinical decision support that are in accord with the Quality Data Model, retooling of a subset of existing NQF-endorsed measures into electronic measure format, development of a public Web site to make available current NQF activities, and development of evaluation criteria for the endorsement of efficiency and resource use measures. In response to a time-sensitive Affordable Care Act requirement, a new short-term task was added for NQF to provide input into the national priorities for consideration under for the National Strategy Quality for Improvement in Healthcare. The NQF convened the National Priorities Partnership (NPP) and delivered a report that provided actionable input for improvement in population health and in the delivery of health care services.

The Secretary has reviewed the annual report and has the following comments. First, the Secretary notes an inadvertent statement in the annual report that appears at the end of the second paragraph in the section entitled ''II. About the National Quality Forum''. It refers to the Consensus Development Process (CDP) and states that ''strict adherence to this CDP qualifies NQF as a voluntary consensus standards-setting organization, granting its endorsed measures special legal standing''. The CDP qualifies the NQF as a voluntary consensus standards-setting organization, and therefore, the endorsed measures are granted standing as voluntary consensus standards. The endorsed measures are not granted special legal standing. This same issue also arises in the section entitled ''III. About the Contract'' in the second bullet following the third paragraph. The sentence includes the statement that the CDP grants the ''measures and practices special legal standing as voluntary consensus standards''. The CDP grants the measures and practices standing as voluntary consensus standards, but does not grant the measures special legal standing.

Second, the Secretary wishes to clarify a statement that has the potential to be misleading. This statement is included in the annual report's section entitled ''II. About the National Quality Forum''. It appears in the third sentence of the sixth paragraph. This sentence mischaracterizes the quality programs described. In particular, CMS is not ''measuring'' meaningful use for purposes of the EHR program. Rather, if eligible professionals and hospitals are able to demonstrate that they meet the requisite meaningful use criteria, they will receive an incentive payment. In addition, *Hospital Compare* is an internet Web site on which the performance of certain providers is reported; it is not a quality reporting program. The correct reference is to the Medicare Inpatient Quality Reporting program.

Third, the Secretary wishes to clarify a statement in the subsection entitled ''Implementation of a Consensus Process for the Endorsement of Quality Measures (Task 7)'' in the section entitled ''IV. HHS–Funded Work''. The fourth sentence in the first bullet point under the heading ''Patient Safety'' within that subsection could be misleading. It states: ''*Serious Reportable Events* has become the foundation of HHS's program of denial of payment for certain hospital-acquired conditions and for many state based adverse event reporting initiatives.'' This sentence could be interpreted to mean that the NQF's list of serious reportable events is the only basis for HHS's denial of payment for certain hospital-acquired conditions, which is inaccurate.

Fourth, a sentence in the subsection entitled ''Technical Infrastructure to Support Measurement Using an Electronic Platform'' within the section entitled ''I. Executive Summary'' states that the American Recovery and Reinvestment Act of 2009 (ARRA) ''provides $20 billion for investment in health IT and use of that technology to improve patient care.'' Similarly, a sentence in the subsection entitled ''Promotion of Electronic Health Records (Task 9)'' within the section entitled ''IV. HHS–Funded Work'' states that ARRA ''provides a $20 billion mandate to ensure health IT plays a central role in transforming the EHR Incentive Program and its meaningful use provisions * * *.'' ARRA does not specify an amount of funding for the EHR Incentive Program. The final amount will depend on the numbers of providers and professionals that participate in the program and their specific years of participation. ARRA also appropriated $2 billion for the Office of the National Coordinator for Health Information Technology (ONC).

Finally, the information describing Task 9.7 (Measure retooling for EHRs) in Appendix A; Summary of Accomplishments Under the Contract: Jan. 14, 2010 to Jan. 12, 2011 warrants further clarification. During the reporting period, the specifications for 113 measures were drafted and updated. They are undergoing review and public comment and will be further updated by December 2011. The Web site where the measures and eSpecifications were posted for public comment is included in Appendix A.

The Secretary is pleased with the progress and timeliness of the work outlined in the Annual Report.

V. Future Steps

The consensus-based contract with NQF is a four year contract. During this second full performance year of the contract, NQF completed deliverables for each task required by MIPPA and for the short-term requirements of section 3014 in ACA. HHS will continue to task NQF with single year and multi-year projects.

Formulation of a National Strategy and Priorities for Health Care Performance Measurement

During March 2010 to February 2011, NQF recommended eight priority areas for national action to the Department for the National Health Care Quality

Strategy. Two were new: To ensure all patients have access to affordable, timely and high quality care; and to provide infrastructure supports, such as health IT, to address underlying system changes that are necessary to attain the goals of other priorities. The original six priorities were: Patient and family engagement; population health; safety; care coordination; palliative and end-of-life care; and overuse of resources. During the year NQF continued its work on the requirements of MIPPA section 183.

The NQF Prioritization Measure Advisory Committee continued to explore priorities for health care performance measurement and developed a list of 20 prioritized high-impact Medicare conditions and measurement gaps. These conditions account for more than 90 percent of Medicare costs. This work complemented the NPP's additional focus on ''cross-cutting'' areas which affect all or most patients, such as care coordination.

Consensus Development Process for Measure Development

The NQF portfolio includes 625 measures organized into five major categories of quality health care: Patient outcomes; care processes; patient experience; resource use; and composite measures. The measures are used in a variety of provider settings, such as ambulatory care settings, emergency service settings and nursing homes, which operate with different data reporting platforms. To meet the various platform needs, measures need to accommodate paper records, and administrative and claims data. During the year, additional work focused on the endorsement of measures of the 20 high-impact Medicare conditions as well as measures for patient safety, nursing homes and child health. Simultaneously, the NQF conducted reviews for potential endorsement of 62 measures that fit into the five categories above.

Maintenance of Consensus-Based Endorsed Measures

During March 2010 to February 2011, NQF maintained endorsed measures relevant to HHS-wide programs and will continue to maintain consensus-based endorsed measures as developed under the priority process.

Promotion of Electronic Health Records

During March 2010 to February 2011, NQF continued to support the promotion of electronic health records as part of HHS-wide efforts. NQF's contributions during the year focused on four areas: (1) Enhancement of the Quality Data Model, which specifies the necessary data for electronic and personal health records; (2) standardization of eMeasure format for use by more than 50 measure developers; (3) re-specification of a subset of performance measures into eMeasures for use with electronic health records; and (4) identification of types of measures for use in determining whether clinicians are properly using electronic health records as well as to detect any unintended consequences. Initial work was undertaken during the year to incorporate the eMeasure format into a Measure Authoring Tool.

Focused Measure Development, Harmonization, and Endorsement Efforts To Fill Critical Gaps in Performance Measurement

During March 2010 to February 2011, NQF continued to support a variety of performance measurement efforts focused on efficiency, harmonization, the ICD–10 and regionalized emergency care services. Both harmonization and ICD–10 activities that were specified for work were complete within the year. NQF made progress in the area of efficiency with two tasks nearing completion and another undertaken during the year. NQF also initiated work on regionalized emergency care services mid-way through the year and progress in that area continues.

During the next contract year, NQF will focus its work on fulfilling the requirements of ACA section 3014 in addition to the continuation of work as required under MIPPA. NQF will also undertake work to provide further input into the annual National Quality Strategy and selection of quality measures for use in public and private reporting programs and value-based purchasing programs. This work will be included in subsequent annual reports.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the paperwork Reduction Act of 1995 (44 U.S.C. 35)

Dated: August 26, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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