

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Document Identifier: OS–0990–New]

Agency Emergency Information Collection Clearance Request for Public Comment

AGENCY: Office of the Secretary, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of a proposed information collection request for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

To obtain copies of the supporting statement and any related forms for the

proposed paperwork collections referenced above, e-mail your request, including your address, phone number, OMB number, and OS document identifier, to Sherette.funncoleman@hhs.gov, or call the Reports Clearance Office on (202) 690–6162. Written comments and recommendations for the proposed information collections must be directed to the OS Paperwork Clearance Officer at the above e-mail address within 30 days.

Proposed Project: Healthy Living Innovation Awards—OMB No. 0990–NEW—Emergency Information Collection Clearance Request—Assistant Secretary Planning Evaluation (ASPE).

Abstract: The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is requesting emergency approval from the Office of Management and Budget (OMB) to receive applications from public and private sector organizations for the Healthy Living Innovation Awards. The project will provide an opportunity for HHS to increase public awareness of creative approaches to develop and expand innovative health promotion programs and duplicate successful strategies in various settings. The Healthy Living Innovation Awards is a new HHS initiative designed to identify and

acknowledge innovative health promotion projects within the last 3 years that have demonstrated a significant impact on the health status of a community. As a part of the Awards selection process interested private and public sector organizations will nominate themselves by completing an online form that asks several questions related to the project and the organization as a whole. The responses to these questions will be used to determine the best-qualified nominees for several award categories. An HHS expert panel will review nominations and make an initial selection of the most promising innovations in each category. An executive summary of the nomination form for the most promising innovations will then be posted on the HHS Healthy Living Innovation Awards Web site for public voting. The Secretary of the U.S. Department of Health and Human Services will make final determination of the award winners in each category based on public votes and recommendations from the HHS expert panel. The Secretary will present awards to the winners in a public recognition ceremony in Washington DC. Data collection activities will be completed within 6 months of OMB clearance.

ESTIMATED ANNUALIZED BURDEN TABLE

Type of respondent	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Organizations (Social and Community Service Managers)	120	1	30/60	60

Seleda Perryman,
Office of the Secretary, Paperwork Reduction Act Reports Clearance Officer.
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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 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

regarding performance measurement as mandated by section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The statute requires HHS to publish not later than six months after receiving the annual report to Congress in the **Federal Register** together with any Secretarial comments.

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. Congress mandated the Secretary of the Department of Health and Human Services (HHS) to contract with a consensus-based entity regarding performance measurement to support HHS' efforts to achieve value as a purchaser of high-quality, patient-

centered, and financially sustainable health care. Section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added section 1890 to the Social Security Act (the Act). The statute mandates that the contract shall be competitively awarded for a period 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' contract activities, if applicable.

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

Formulation of National Strategy and Priorities for Health Care Performance

Measurement—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 decisions; 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—At the request and direction of HHS, 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 website 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 task; 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, as created by section 183 of MIPPA, 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, the first annual 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 Secretary of HHS the second annual report. This notice complies with the statutorily required Secretarial review and publication of the second annual report covering the period of performance of March 1, 2009 through February 28, 2010.

II. March 2010—NQF Report to Congress and HHS Secretary

Submitted in March 2010, the second annual report to Congress and the Secretary spans the period of March 1, 2009 through February 28, 2010.

A copy of NQF's submission of the March 2010 annual report to Congress and the Secretary of HHS can be found at: <http://www.qualityforum.org/projects/ongoing/hhs/>.

The 2010 NQF annual report is reproduced in section III of this notice.

III. NQF March 2010 Annual Report Strengthening the National Quality Infrastructure National Quality Forum Accomplishments Under Contract #HHSM-500-209-00010C

Report to the Congress and the Secretary of the U.S. Department of Health and Human Services, Covering the period of March 1, 2009, to February 28, 2010, Pursuant to PL 110-275 and Contract #HHSM-500-209-00010C

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The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

A Message From the Leadership of the National Quality Forum

Ten years ago, the Institute of Medicine (IOM) exposed the U.S. healthcare system's numerous quality and patient safety deficiencies with the publication of its landmark report, *To Err is Human*.¹ In the decade since, numerous local, regional, and national quality improvement initiatives, including but not limited to programs supported by the federal and state governments, have sought to correct these deficiencies. Many of these activities have borne fruit. Some can definitively be credited with saving American lives.

Despite these successes, and despite the dedicated effort of millions of well-trained, committed, and compassionate healthcare workers, the quality of healthcare in the United States still is not nearly as good as it could or should be. Thousands of Americans die every year, and millions more are injured, as a result of medical error. Processes of care vary widely by region, state, and provider, with no apparent benefit to patients. Healthcare in the United States is plagued by inequities based on race, ethnicity, gender, and other factors.

Costs—including costs to taxpayers—have skyrocketed. Millions of Americans are denied access to care because they lack sufficient insurance.

As the decade progressed, it became clear that the nation's numerous quality initiatives, successful though many may have been, were no substitute for a coordinated national strategy to systematically improve the quality of healthcare in the United States. To help formulate such a strategy, Congress in 2008 passed the Medicare Improvements for Patients and Providers Act (Pub. L. 110–275).² One goal of the legislation is to establish a portfolio of quality and efficiency measures that will allow the federal government to see more clearly how and whether public healthcare spending is achieving the best results for Americans. 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 (DHHS) "to contract with a consensus-based entity, such as the National Quality Forum." This report summarizes the work performed under this contract between March 1, 2009, and February 28, 2010, the first full year that the DHHS contract has been in place.

As we review the work performed over the past year, it becomes apparent that 2009 was a year of building infrastructure to support healthcare quality. Much like physical infrastructure, the nation's healthcare quality infrastructure must be constructed with precise attention to detail, and then maintained so that it meets the expanding needs of those it serves. Priorities and goals must be identified to focus improvement efforts on areas that will yield the greatest gains in terms of improved health and healthcare; and performance measures must be developed, endorsed, and implemented to gauge delivery system progress and reveal opportunities for improvement.

Many of the activities NQF has performed under the DHHS contract are in midstream and extend beyond a single year's worth of work. Nevertheless, we have completed significant work in several areas, including:

- The development of a prioritized set of conditions for quality improvement;
- The endorsement of performance measures in critical gap areas; and
- The establishment of common protocols and standardized formats for e-measure specification and the creation of an electronic measure authoring environment to enable retooling of

performance measures for the assessment of "meaningful use" of health information technology (HIT).

We are grateful to Congress and DHHS for supporting NQF's work in nurturing the quality enterprise in the United States; to the more than 400 institutional members of NQF who have sustained the organization and, in doing so, have helped build the healthcare quality improvement movement; and to NQF's expert panel volunteers and staff, whose tireless efforts on behalf of American patients contribute to a healthcare system that is becoming, as the IOM envisioned, safe, timely, effective, efficient, equitable, and patient centered.

During the last year, we built a stronger foundation for healthcare performance improvement in the United States. We are confident that in 2010 and beyond, Americans will reap the benefits of our healthcare quality infrastructure.

1. Executive Summary

The National Quality Forum (NQF) was created in 1999 to develop and implement a national strategy for healthcare quality improvement. It has grown into an influential consensus-based organization in healthcare in the United States, supported by more than 400 organizational members and boasting a unique structure that enables private and public sector stakeholders to collaborate on cross-cutting solutions to drive continuous performance improvement. NQF's core work includes the establishment of national priorities and the endorsement of performance measures. NQF follows a formal Consensus Development Process recognized under the National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113), which grants its endorsed measures and best practices special legal standing as national voluntary consensus standards.

Section 183 of the Medicare Improvements for Patients and Providers Act (Pub. L. 110–275) of 2008 calls for the Department of Health and Human Services (DHHS) "to contract with a consensus-based entity, such as the National Quality Forum" (NQF) for the purpose of pursuing certain activities relating to healthcare performance measurement. On January 14, 2009, the National Quality Forum was awarded a contract under this Section. The contract provided up to \$10 million for the first year after award with the option for three \$10 million annual renewals. Among other assignments, the contract called for NQF to:

- Develop a prioritized list of conditions that impose heavy health burden on beneficiaries and account for significant costs;
- Identify and endorse measures that can be used by various stakeholders to assess and improve the care provided to beneficiaries with these conditions, and the performance of providers in various healthcare settings; and
- Promote the use of electronic health records (EHRs) for performance measurement, reporting, and improvement.

This report summarizes the work performed under this contract between March 1, 2009, and February 28, 2010, the first full year that the DHHS contract has been in place.

Many of the activities NQF has performed under the DHHS contract are in midstream and extend beyond a single year's worth of work. Under the DHHS contract, NQF has achieved significant accomplishments in the following areas:

- Developed a framework, composed of the 20 priority conditions for Medicare and the six cross-cutting priority areas identified by the NQF-convened National Priorities Partnership, for focusing performance measurement, public reporting, and improvement efforts;
- Conducted an environmental scan of existing performance measures and measures under development, and began constructing a prioritized agenda for measure development and endorsement;
- Initiated endorsement projects to expand the portfolio of NQF-endorsed® measures in key gap areas: Patient outcomes, efficiency, patient safety, and nursing home care;
- Enhanced processes for ongoing "measure maintenance" to ensure that the more than 550 measures that NQF already has endorsed are continuously updated to reflect changes in the evidence base as it evolves and undergo comprehensive assessment on a three-year cycle to maintain "best in class" standing;
- Contracted with an applied research firm to conduct an independent evaluation of its Consensus Development Process;
- Began work on a two-year plan for the evolution of NQF's portfolio of endorsed patient safety measures, "safe practices," and serious reportable events;
- Undertook an environmental scan to review the state of reporting with respect to patient safety events and serious reportable events at the federal and state level;

- Completed an evaluation of the types of data that must be captured in electronic health records (EHRs) to support measurement and improvement on the more than 550 NQF-endorsed performance measures;

- Developed a standardized format (*i.e.*, the Health Quality Measure Format) for representing a health quality measure in a machine-readable electronic format, which has now been approved by HL7 for use in EHRs; and
- Produced an enhanced Web site, featuring an online performance measure submission form, an improved online platform for public comment, and an online directory of NQF-endorsed consensus standards.

Much like physical infrastructure, the nation's Healthcare quality infrastructure must be constructed with precise attention to detail, and then maintained so that it meets the expanding needs of those it serves. In 2009, under the DHHS contract, NQF took great strides in building and supporting that infrastructure. In 2010 and beyond, the United States will reap significant benefits from investments in this quality infrastructure, which is critical to support expanded public reporting and payment reform and foster continuous quality improvement in American healthcare.

2. 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. Section 183 of the Act, among other things, directs the Secretary of DHHS 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–500–209–00010C, under Section 183 of the Medicare Improvements for Patients and Providers Act. The DHHS contract is administered by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), which provides strategic leadership and technical insight for the contract, and by the Centers for Medicare & Medicaid Services (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 called for NQF to:

- Develop a prioritized list of conditions that impose heavy health burden on beneficiaries and account for significant costs;

- Identify and endorse measures that can be used by various stakeholders 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.

While the work conducted under the contract is intended specifically to benefit all those served by DHHS 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 and recent accomplishments in three areas:

- **Setting 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.

- **Endorsing performance measures.** NQF has endorsed more than 500 performance measures and best practices under its formal Consensus Development Process, granting those measures and practices special legal standing as voluntary consensus standards.

- **Facilitating the development of EHRs to support measurement and improvement.** NQF has worked to identify the types of information that need to be included in an EHR to enable reporting on quality metrics.

Under the contract, DHHS 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 be attributable to providers where possible. A premium must be placed on developing measures in key areas that will have the greatest impact in improving quality and value, rather than focusing on developing a large number of measures that may be easiest to produce, such as process measures.”

The contract is divided into 12 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 six 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 the endorsement of healthcare quality measures. Task 7 includes an evaluation of NQF's Consensus Development Process and the conduct of consensus 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. Task 12 is divided into three subtasks: Efficiency, harmonization, and ICD–10.

Details of work performed under the DHHS contract in each of these tasks are found in Section 3 of this report.

3. Work Performed by the National Quality Forum Under the DHHS Contract in 2009

This section describes details of work performed under each task according to the DHHS contract in the past year.

National Strategy and Priorities (Task 6)

A two-dimensional framework—consisting of leading conditions and cross-cutting areas—has been developed to focus performance measurement and improvement on high-leverage areas having the greatest potential to improve health and healthcare. Starting with the Medicare 20 priority conditions, which collectively account for 95 percent of Medicare expenditures (*see Exhibit A*), an expert panel is working to prioritize these conditions based on cost, prevalence, improvability, variability, and disparities. The second part of the strategy builds on work previously performed by the National Priorities Partnership,³ 32 major national healthcare stakeholder organizations (*see Appendix D*) convened by NQF, which identified six crosscutting priority areas that affect many conditions: Patient and family engagement, population health, safety, care coordination, palliative and end-of-life care, and overuse.⁴ To identify gaps, currently available performance measures have been mapped to this framework.

To further inform the process of setting an agenda for measure

development and endorsement, NQF is convening experts and gathering information to identify specific types of measures needed to support Medicare payment and public reporting programs, “meaningful use” of HIT, and other applications. This work is scheduled for completion in the third quarter of 2010.

Exhibit A: Medicare 20 Priority Conditions

To assist in carrying out its responsibilities, in 2009 NQF issued a firm, fixed-price contract for a qualified contractor to perform a systematic review and synthesis of evidence relating to 20 high-priority conditions identified by the Centers for Medicare & Medicaid Services. Patients with these conditions account for more than 95 percent of Medicare’s costs. The 20 conditions (not in any order of priority) are:

- Acute myocardial infarction
- Alzheimer’s disease and related disorders
- Atrial fibrillation
- Breast cancer
- Cataract
- Congestive heart failure
- Chronic kidney disease
- Colorectal cancer
- Chronic obstructive pulmonary disorder
- Diabetes
- Endometrial cancer
- Glaucoma
- Hip/pelvic fracture
- Ischemic heart disease
- Lung cancer
- Major depression
- Osteoporosis
- Prostate cancer
- Rheumatoid arthritis and osteoarthritis
- Stroke/transient ischemic attack

Consensus Development Process for Measure Endorsement (Task 7)

The stakeholder-based endorsement of performance measures via a formal Consensus Development Process (CDP) has long been NQF’s “stock in trade.” This task involves both a formal evaluation of the endorsement process and the conduct of a set of endorsement projects focused on known measure gap areas.

Evaluation of the Consensus Development Process. NQF follows a nine-step process (*Exhibit B*) to evaluate and endorse consensus standards, including performance measures, serious reportable events, best practices, measurement frameworks, and reporting guidelines. The process is designed to ensure that performance measures endorsed by NQF satisfy certain criteria (*i.e.*, importance, scientific

acceptability, usability, and feasibility) and represent the “best in class.” The process is transparent and provides for extensive input from all stakeholders. Over the past 10 years, the steps that form NQF’s Consensus Development Process and its implementation have evolved to ensure that evaluation of Candidate Consensus Standards continues to follow best practices in performance measurement and standards setting. In 2009, under the DHHS contract, NQF contracted with Mathematica Policy Research Inc. to conduct an independent evaluation of the Consensus Development Process. This evaluation also includes gathering information on similar processes of other standard-setting bodies, which is expected to be useful in further refining NQF’s endorsement process. This report is scheduled for completion in October 2010, with the proposed enhancements to the Consensus Development Process scheduled to be considered in January 2011.

Exhibit B: NQF Consensus Development Process (Version 1.8)

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 Decision.
8. Board Ratification.
9. Appeals.

Endorsement Projects. The current DHHS contract facilitates a coordinated, strategic approach to endorsing performance measures.

As noted above, efforts are underway to develop a comprehensive agenda for measure development and endorsement, which will guide future endorsement work. During this first year of the DHHS contract, the schedule of endorsement projects was determined through a collaborative process involving representatives from the various DHHS departments and NQF, targeting well-known gap areas. On average, it takes less than one year to complete the nine-step Consensus Development Process. Endorsement projects fall into two broad categories: Quality and efficiency, and patient safety.

Quality and Efficiency. Many projects in this area focus on measures of patient outcomes and efficiency, thus laying the groundwork for assessing the “value” received from healthcare services. Considerable attention also is paid to settings outside the hospital and to care transitions.

• **Patient outcome measures.** This three-phase project focuses on cross-cutting and condition-specific outcome measures. Specifically, outcome measures will be endorsed for patients with Medicare high priority conditions, such as: Congestive heart failure, chronic obstructive pulmonary disease, arthritis, diabetes, depression, and several types of cancers. There is also a phase of work dedicated to outcome measures for children. The conditions included in each phase are:

- *Phase I:* Cardiovascular diseases, including acute myocardial infarction, ischemic heart disease, congestive heart failure, atrial fibrillation, and stroke/transient ischemic attacks, metabolic diseases, including diabetes and chronic kidney disease; and pulmonary diseases, including asthma and chronic obstructive pulmonary disease.
- *Phase II:* Cancer, including breast, lung, colorectal, and endometrial cancers; bone/joint diseases, including hip fracture, osteoporosis, and arthritis; and infection, including pneumonia.
- *Phase III:* Child health and mental health. In future years, measures derived from this phase include a core measure set for the Children’s Health Insurance Program Reauthorization Act of 2009.

• **Nursing home measures.** This project focuses on the endorsement of performance measures for nursing homes. It will include an updated set of measures to assess and improve care provided in nursing homes.

Patient Safety. NQF has a sizable portfolio of endorsed serious reportable events, patient safety measures, and safe practices that are used extensively by DHHS and states in reporting and payment programs, and by providers for improvement purposes. On October 6, 2009, NQF convened the Patient Safety Advisory Committee to assess current initiatives and develop a two-year strategic work plan for the evolution of the NQF portfolio. This strategic plan, when completed in fall 2010, will guide NQF’s safety work in 2011 and 2012. The initial set of 2009 projects focuses on known gap areas.

• **Serious Reportable Events (SREs).** NQF has long been a pioneer in this area, dating to its 2002 report *Serious Reportable Events in Healthcare: A Consensus Report*, which listed 27 preventable events leading to death or serious injury that should be publicly reported. (The program was updated in 2006, with a 28th event added.) This list formed the core of the Medicare non-payment program for healthcare-acquired conditions, as well as many state-based adverse event reporting initiatives. This project will consider

expanding the list of serious reportable events to include events that are applicable to additional non-hospital settings, such as nursing homes and ambulatory care settings. The project includes convening representatives of state-based adverse event-reporting agencies to review the current environment of adverse event reporting systems, related issues, and unintended consequences, as well as to obtain their input on the next generation of events.

- **Patient safety measures.** This project focuses on key safety measures such as healthcare-associated infections. As a part of this project, currently endorsed infection measures will be updated to reflect updated case definitions from the Centers for Disease Control and Prevention. Other focus areas for patient safety measures will include condition specific measures and reviewing applicability of safety measures to a variety of environments of care.

- **Patient safety public reporting guidelines.** Public reporting of patient safety performance results can be challenging, especially for serious reportable events and low-frequency safety events. This project aims to develop a framework and guidelines for measuring, evaluating, and publicly reporting patient safety information across the spectrum for severity and frequency of events.

Maintenance of Previously Endorsed Measures (Task 8)

Healthcare performance measures and similar consensus standards are useful for improving quality only as long as the standards reflect current knowledge and state-of-the art, high-quality care. The maintenance of NQF-endorsed measures is of critical importance because the science underlying both clinical practice and safe, effective, and efficient care delivery evolves over time. Ongoing maintenance processes also ensure that measure specifications reflect updates in coding systems, such as ICD-10-CM.

Specifically, the currency of the NQF portfolio refers to four factors:

1. **Importance of the Measure Topic.** Does the measure reflect current clinical science and guidelines? Is there still a gap between actual and ideal performance? (Or is the measure “topped out?”)

2. **Measure Specifications.** Do the specifications reflect current coding and classification systems? (In addition, as discussed below, future maintenance processes will require stewards to submit e-specifications so measures can be used with electronic health records.)

3. **Harmonization.** There are currently dozens of measure developers, all of whom follow different conventions and practices when specifying measures. Through its endorsement and maintenance processes, NQF works with measure stewards to harmonize their measures. Harmonization facilitates the use of measures in sets (e.g., a composite measure for patients with diabetes that reflects the outcomes and clinical process measures for a patient-focused episode) and makes it easier to understand and interpret results. Harmonization also lessens the burden of implementation.

4. **Best in Class.** There is much innovation in the development of measures. NQF-endorsed measures are subject to a competitive review every three years in which they must demonstrate “best in class” when compared directly with other candidate measures.

In 2009, NQF developed a comprehensive schedule for review of measures pertaining to the leading conditions and the National Priorities Partnership cross-cutting areas. The new measure maintenance schedule will provide an annual update of measure specifications. Measures will undergo a comprehensive review at least every three years, including harmonization and best in class considerations. In addition to scheduled maintenance, ad hoc maintenance reviews are conducted if there are significant changes in the science base requiring immediate attention or concerns are raised about untoward consequences of measurement.

Promotion of EHRs (Task 9)

It is broadly recognized that EHR systems can improve the quality of care delivered to patients. Health information technology (HIT)-enabled content and transactions can make important healthcare information more readily available to those who need it when they need it. If implemented with careful attention to workflow and content needs, EHR systems will appreciably improve the safety, effectiveness, and efficiency of American healthcare, leading to widespread and sustainable quality improvement. Such systems will support clinical decisions; grant patients and clinicians access to health records and improve the accuracy of those records; seamlessly integrate clinical and payment functions; and facilitate the collection, reporting, and analysis of quality data.

- **The “eMeasure.”** In 2009, NQF developed and oversaw standardization of the Health Quality Measure Format,

commonly known as the “eMeasure,” representing a health quality 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 a critical component of the workflow to support “meaningful use” of electronic records as described by the American Recovery and Reinvestment Act of 2009. The eMeasure was successfully balloted by the technical standards development organization HL7 at its September 2009 workgroup meeting. The sponsoring workgroup, Structured Documents, approved the ballot as a draft standard for trial use on November 4, 2009. The measure was successfully tested in the HITSP Connectathon in January 2010.

- **Measure Retooling.** In 2009, under the DHHS contract, NQF undertook implementation of its previously completed Quality Data Set (QDS) ⁵ (see *Exhibit C*) by applying the QDS to measures already endorsed by NQF. NQF staff created an authoring environment for the retooling effort to manage consistency with the QDS and to make the process as efficient as possible. That environment is complete and will be used by measure developers to retool high-priority measures requested by CMS.

- **QDS Model and Repository.** In the contract’s first year, some work on standardizing the management of code lists was performed in the standards harmonization process in the Healthcare Information Technology Standards Panel (HITSP) in summer 2009. The HIT Standards Committee has now established a task force on vocabulary, which began work in January 2010 to define the governance and infrastructure rules for vocabulary management. NQF’s participation in that task force supports the registry requirements in a stand.

Exhibit C: About the QDS

The Quality Data Set (QDS), 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 quality measures. It is a classification system by which measure developers can offer and refine definitions. Once fully developed, the QDS will be a centralized repository of quality data requirements (such as concepts, data types, data elements, and code lists) and data definitions used by multiple stakeholders to develop, specify, and use quality measures. The QDS aims to provide direction to

measure developers, EHR vendors, and other stakeholders on how to define quality terminology without ambiguity. Although the QDS was developed under an earlier grant from the Agency for Healthcare Research and Quality, its implementation is covered under the current DHHS contract and manner.

- **Measure Authoring Tool and Guidelines.** In 2009, NQF identified requirements for a measure authoring tool and created a prototype environment for use in the measure retooling effort. An NQF tooling/retooling guide is planned that will expand on that effort, and a more detailed authoring tool will be available for use to create electronic measures in January 2011.

- **Linking Performance Measurement to Clinical Decision Support.** NQF convened a Clinical Decision Support Expert Panel, which met on November 11–12, 2009. The panel created a clinical decision support taxonomy framework and adapted the QDS data requirements to support clinical decision support.

The Development of a Public Web Site (Task 11)

NQF in 2009 undertook an effort to redevelop its own Web site to guarantee that its proceedings would be fully transparent to all stakeholders. The Web site, <http://www.qualityforum.org>, is now fully operational and features an electronic measure submission form to enhance the Consensus Development Process and measure maintenance activities. Specifically, funding from the DHHS contract in this task was used to:

- Produce a new Web site for information about NQF's Consensus Development Process and its specific projects, including their status and opportunities for public and member input;
- Implement additional Web site features; and
- Perform ongoing management of web-based content.

The site was developed and is operated using a content management system to support better content organization and maintenance and editorial oversight. The implementation included integration with other NQF systems and laid a technological foundation that will enable future enhancements. Achievements resulting from this work include:

- A new structure for project information that clearly presents the progress of work through NQF's Consensus Development Process and supports and encourages public review and input;

- Site personalization for registered users, including a dashboard in which users can access information about their participation in NQF activities;

- An online measure submission form and process that improves the electronic collection and dissemination of the information needed to evaluate performance measures for potential endorsement;

- An improved online voting platform, including the ability for users to see the status of their organization's participation; and

- An online directory of NQF-endorsed consensus standards.

Measurement Development, Harmonization, and Endorsement (Task 12)

The DHHS contract provides for measure development and related activities to fill gap areas. In 2009, NQF published requests for proposals for "indefinite need, indefinite quantity" contracts to build capacity in case DHHS decides that performance measures are needed in any given area. This capacity was not requested by DHHS in the first year of the contract. Other specific projects under this task included:

- **Harmonization.** To identify gaps in appropriate care at the appropriate junctures, work is needed to adopt global, harmonized quality measures in all settings. The opportunity to link measurement across providers and sites of care will form the foundation for a systems-based perspective to healthcare delivery, the reduction or elimination of preventable illnesses, and the delivery of high-quality care. Thus, NQF is planning to identify the steps needed to achieve harmonization, including how to encourage measure developers to achieve measure harmonization with measures across sites and providers of care. This work is ongoing.

- **Efficiency and resource use measures.** The current portfolio of NQF measures contains very limited numbers of performance measures to assess efficiency and resource use. In its new phase of work, NQF has received 18 measures in mammography, appropriate use of CT scans, and cardiac imaging. A second phase of work will focus on measures of episode-based resource use.

- **ICD–10.** DHHS utilizes various code sets to classify medical care for purposes of payment and performance measurement. The International Classification of Diseases (ICD) code set⁶ is used to identify diagnoses (diseases, injuries, and impairments) and procedures (diagnosing, managing, treating, preventing). DHHS intends to convert from the ICD, Ninth Revision

(ICD–9) to ICD, Tenth Revision, Clinical Modification (ICD–10–CM) by 2013. In this project, NQF is examining the implications of additional code set requirements on performance measures and developing guidance and a schedule for updating measures by the 2013 coding conversion deadline. In 2009, NQF convened an expert panel to consider coding issues and how they affect performance measurement, including defining and laying out a process for responding to "material changes" in measures that may result from the coding conversion process. This work is ongoing.

4. 2010 and Beyond: A Look Ahead

The decade since IOM published *To Err is Human* has seen the maturation of the modern-day healthcare quality improvement movement in the United States. It is no longer accepted as a matter of faith that the United States boasts the "best healthcare system in the world." Today, we know that despite the heroic effort of millions of dedicated individuals, healthcare quality is deficient in many areas. Further, we know that healthcare quality is measurable, and that quality deficiencies must be measured—with the results of these measurements publicly reported—if we hope to correct them. This recognition, while sobering, has led to a national commitment to improve the quality of healthcare for all Americans. Following this commitment, the recognition has led to the construction of a national infrastructure for quality improvement—including the formulation of national priorities, the use of agreed-upon performance measures to gauge quality, and an EHR system to collect and disseminate performance data.

As the quality movement has matured, so too has the National Quality Forum. When the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry proposed the creation of a forum that would convene disparate stakeholders to formulate a national strategy for healthcare quality, the idea seemed novel. Today, NQF is itself a firmly entrenched stakeholder, advocating for healthcare quality improvement while serving no interest other than that of the public at large.

NQF's work today supports key DHHS work outlined in the American Recovery and Reinvestment Act of 2009 in three important ways:

- Supporting the HIT provisions by ensuring that EHRs have the necessary capabilities to foster performance measurement and public reporting;

- Focusing performance improvement activities on reducing healthcare-associated infections and enhancing chronic disease outcomes; and
- Identifying key gaps in the evidence base to sustain the Recovery Act's comparative effectiveness research goals.

NQF remains firmly committed to a broad, quality-focused transformation of the healthcare system, including supporting goals in quality, access, and affordability that may be achieved through national health reform legislation.

The focus of the American quality improvement endeavor has moved beyond measures of process to include measures of outcomes that matter most to patients. In response to soaring healthcare costs, efforts are now underway to develop and endorse efficiency measures that can be used to remove waste and unnecessary services from the healthcare system. This shift is fraught with challenges as the healthcare industry seeks to find and agree upon measures that are important, scientifically acceptable, usable, and feasible—and is subject to controversy because results of these measures will be used in payment and public reporting programs.

The quality infrastructure we are building today will be important for decades to come. It is a fundamental building block for transforming the American healthcare system to provide patient-centered care that is safe, effective, and affordable.

The National Quality Forum, Washington, DC, March 1, 2010.

5. Appendices and Notes

Appendix A: About National Quality Forum

The National Quality Forum is a nonprofit organization that aims to improve the quality of healthcare for all Americans through fulfillment of its three-part mission:

- Setting national priorities and goals for performance improvement;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.

NQF was created in 1999 at the recommendation of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.⁷ Today, it is uniquely positioned to serve as a national coordinating and standard-setting center for performance measures. The NQF Board of Directors includes public- and private-sector representatives, with a simple majority of its at-large seats held by consumers and those who purchase services on their behalf. (See Appendix B.) It works

collaboratively with multiple quality alliances, and has unmatched experience in evaluating and endorsing measures of healthcare performance, many of which are in widespread use. From its inception, NQF sought to convene disparate stakeholders to work toward the common goal of improving healthcare quality by advancing performance measurement and public reporting. NQF member organizations are organized into eight member councils—consumers; purchasers; healthcare professionals; health plans; provider organizations; public/community health agencies; quality measurement, research and quality improvement organizations; and suppliers and industry.

Adhering to the National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113)⁸ and the Office of Management and Budget's definition of consensus,⁹ NQF endorses performance measures, best practices, serious reportable events, measurement frameworks, and reporting guidelines through its formal Consensus Development Process,¹⁰ which is designed to call for input and carefully consider the interests of stakeholder groups from across the healthcare industry. The strict adherence to this Consensus Development Process qualifies NQF as a voluntary consensus standards-setting organization, granting its endorsed measures and best practices special legal standing. NQF's work can be divided into three broad categories:

1. **National Priorities and Goals.** In 2008, NQF embarked on the nation's largest effort to determine national priorities for healthcare quality improvement. NQF convened the National Priorities Partnership (NPP), a diverse group of 32 major national organizations representing those who receive, pay for, deliver, and evaluate healthcare. (See Appendix D.) The NPP, co-chaired by Donald M. Berwick, MD, MPP, president and CEO of the Institute for Healthcare Improvement, and Margaret E. O'Kane, president of the National Committee for Quality Assurance, sought to set in motion a national movement to deliver transformative improvements to the nation's health and healthcare system. In 2008, the NPP released a landmark action agenda, with six priorities to transform healthcare during a time of severe economic strain by better investing resources to fundamentally improve patient care and outcomes. These priorities and the specific, measurable actions springing from them guide much of NQF's ongoing work.

2. **Endorsement of Consensus Standards.** The careful evaluation and endorsement of consensus standards is central to NQF's ongoing mission to improve the quality of American healthcare. Using its rigorous Consensus Development Process, NQF fosters consensus among a wide variety of stakeholders around specific standards that can be used to measure and publicly report healthcare quality. NQF endorses several different kinds of consensus standards, each of which can be used to assess different aspects of healthcare quality: performance measures, practices, frameworks, and reporting guidelines. To date, NQF has endorsed more than 550 consensus standards.

○ **Performance Measures.** Measures gauging the performance of healthcare endorsed by NQF are used for measuring and publicly reporting on the performance of different aspects of the healthcare system and are widely viewed as the “gold standard” for the measurement of healthcare quality. One early model for the implementation of NQF endorsed performance measures was *National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set*.¹¹ This report contained 39 performance measures gauging the quality of care delivered in hospitals. It was endorsed through NQF's Consensus Development Process. These hospital measures took on additional importance when 10 of them became the “starter set” of measures employed by the Hospital Quality Alliance¹² and CMS's Hospital Compare¹³ to encourage public reporting of hospital performance measures.

○ **Patient Safety.** NQF has an established track record of national leadership regarding patient safety. Two of its very early projects launched NQF's work in this area. The first was *Serious Reportable Events in Healthcare: A Consensus Report*,¹⁴ in which NQF named 27 events leading to death or serious injury that should not occur in any healthcare setting, but unfortunately do, and should be publicly reported when they do occur. These events and their NQF revisions became the cornerstone of many state-based adverse event-reporting initiatives and of CMS's policies regarding payment for healthcare-acquired conditions. The second was *Safe Practices for Better Healthcare: A Consensus Report*,¹⁵ a set of 30 practices that, if universally applied in all clinical care settings, would substantially reduce the risk of error and harm for patients. These practices have become the standard by which many healthcare organizations measure their patient safety goals and strategies. Both of these reports have been revised twice since initial publication.

3. **Education and Outreach.** As part of its ongoing commitment to the advancement of healthcare quality, NQF produces a variety of publications, such as issue briefs; conducts educational outreach sessions such as webinars; sponsors an annual conference that brings together healthcare and community leaders to develop national solutions to quality concerns; convenes healthcare executives annually for an invitational Leadership Colloquium; and sponsors two annual recognition programs, the National Quality Healthcare Award and the John M. Eisenberg Patient Safety and Quality Awards, highlighting the achievements of professionals and providers.

In 2008, Congress provided a clear mandate and a stable funding stream to address gaps and weaknesses that stood between today's realities and the creation of a coherent national system for establishing performance measures. High-quality standardized performance measures are a public need as well as a public good that benefits all stakeholders. In 2009, NQF was awarded a contract with DHHS under the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275). The contract provided \$10 million for year after

award, with the option for three \$10 million annual renewals. This contract granted NQF a stable source of core funding to pursue this important work in a coordinated, strategic manner.

Today, NQF is one of the largest consensus-based organizations in healthcare in the United States. Its more than 400 organizational members represent every aspect of the U.S. healthcare system. It has evolved into a truly broad, fully representational organization supporting the nation's quest for a "true north" for healthcare quality. Its strength lies in the active participation of its broad, diverse membership. NQF's unique structure enables private- and public-sector stakeholders to work together to craft and implement cross-cutting solutions to drive continuous quality improvement in the American healthcare system. NQF remains committed to maintaining a constant drumbeat for healthcare quality.

Appendix B: NQF Board of Directors

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

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

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

Richard J. Baron, MD, President and CEO, Greenhouse Internists.

Bruce Bagley, MD, Medical Director for Quality Improvement, American Academy of Family Physicians.

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

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

Carolyn M. Clancy, MD, Director, Agency for Healthcare Research and Quality.

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

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

Maureen Corry, MPH, Executive Director, Childbirth Connection.

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

Charlene Frizzera, Acting Administrator, Centers for Medicare & Medicaid Services.

Robert Galvin, MD, Director of Global Healthcare, General Electric.

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

Karen Ignagni, MBA, President & CEO, America's Health Insurance Plans.

Chris Jennings, President, Jennings Policy Strategies, Inc.

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

Peter V. Lee, JD, Executive Director of National Health Policy, Pacific Business Group on Health.

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

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

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

Mary Naylor, PhD, RN, Marian S. Ware Professor in Gerontology at the University of Pennsylvania School of Nursing, and Director of NewCourtland Center for Transitions and Health.

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

Nancy H. Nielsen, MD, PhD, Immediate Past President, American Medical Association.

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

J. Marc Overhage, MD, PhD, Director of Medical Informatics, Regenstreif Institute.

Bernard M. Rosof, MD, Chair, Board of Trustees, Huntington Hospital.

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

Curt Selquist (Chair, Leadership Network, *ex officio*), Johnson & Johnson Healthcare Systems, Inc. (retired).

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

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

Andrew Webber, President and CEO, National Business Coalition on Health.

Appendix C: Key NQF Staff Working Under the DHHS

Janet M. Corrigan, PhD, MBA, President and Chief Executive Officer.

Helen Burstin, MD, MPH, Senior Vice President for Performance Measures.

Floyd Eisenberg, MD, MPH, FACP, Senior Vice President for Health Information Technology.

Laura Miller, MPA, Senior Vice President and Chief Operating Officer.

Thomas Valuck, MD, MHSA, JD, Senior Vice President for Strategic Partnerships.

Karen Adams, PhD, Vice President of National Priorities.

Alicia C. Aebersold, Vice President of Communications.

Marybeth A. Farquhar, PhD, MSN, RN, Vice President for Performance Measures.

Lawrence D. Gorban, MA, Vice President of Operations.

Bruce Pelleu, CPA, Chief Financial Officer.

Peter B. Angood, MD, FRCS(C), FACS, FCCM, Senior Advisor, Patient Safety.

Alexis Forman, MPH, Program Director, Performance Measures.

Margaret Kay, Director of Publications.

Lindsay Lang, MHSA, RN, Program Director, Performance Measures.

Nicole Williams McElveen, MPH, Program Director, Performance Measures.

Karen Pace, PhD, RN, Senior Program Director.

Ashlie Willbon, MPH, RN, Program Director, Performance Measures.

Appendix D: National Priorities Partnership

AAR

AFL-CIO

Agency for Healthcare Research and Quality
Aligning Forces for Quality
Alliance for Pediatric Quality
America's Health Insurance Plans
American Board of Medical Specialties
American Health Care Association
American Nurses Association

AQA

Centers for Disease Control and Prevention

Centers for Medicare & Medicaid Services

Certification Commission for Health

Information Technology

Consumers Union

Hospital Quality Alliance

Institute for Healthcare Improvement

Institute of Medicine

Johnson & Johnson

Leapfrog Group

National Association of Community Health Centers

National Business Group on Health

National Committee for Quality Assurance

National Governors Association

National Institutes of Health

National Partnership for Women & Families

National Quality Forum

Pacific Business Group on Health

Physician Consortium for Performance

Improvement convened by the American Medical Association

PQA

Quality Alliance Steering Committee

The Joint Commission

U.S. Chamber of Commerce

Notes

¹ Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err is Human: Building a Safer Health System*. Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC: National Academy Press; 2000.

² Medicare Improvements for Patients and Providers Act (Pub. L. 110-275). Available online at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h6331enr.txt.pdf. Last accessed December 2009.

³ National Priorities Partnership (NPP). Available online at <http://www.nationalprioritiespartnership.org/>. Last accessed December 2009.

⁴ NPP. *National Priorities & Goals: Aligning Our Efforts to Transform America's Healthcare*. Washington, DC: National Quality Forum (NQF); 2008.

⁵ NQF. *Policy Brief: HITEP II*. Issue Brief No. 17; October 2009. Washington, DC: NQF; 2009.

⁶ International Classification of Diseases. Available at <http://www.who.int/classifications/icd/en/>. Last accessed January 2010.

⁷ President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. *Quality First: Better Health Care for All Americans*. March 12, 1998. Available online at <http://www.hcqualitycommission.gov/final/>. Last accessed December 2009.

⁸ National Technology Transfer and Advancement Act of 1998 (Pub. L. 104-113). Available online at <http://ts.nist.gov/standards/information/113.cfm>. Last accessed December 2009.

⁹ U.S. Office of Management and Budget. Circular No. A-119, February 10, 1998.

Available online at <http://www.whitehouse.gov/omb/rewrite/circulars/a119/a119.html>. Last accessed December 2009.

¹⁰ NQF. NQF Consensus Development Process, v. 1.8. Available online at http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx. Last accessed December 2009.

¹¹ NQF. *National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set*. Washington, DC: NQF; 2003.

¹² Hospital Quality Alliance: Improving Care Through Information. Available online at <http://www.hospitalqualityalliance.org/>. Last accessed December 2009.

¹³ Hospital Quality Compare—A quality tool provided by Medicare. Available online at www.HospitalCompare.hhs.gov. Last accessed December 2009.

¹⁴ NQF. *Serious Reportable Events in Healthcare: A Consensus Report*. Washington, DC: NQF; 2002.

¹⁵ NQF. *Safe Practices for Better Healthcare: A Consensus Report*. Washington, DC: NQF; 2003.

IV. Secretarial Comments on the Annual Report to Congress

The Secretary is pleased with the scope and vision of NQF's March 2010 annual report. An internal multidisciplinary cross-component HHS team is working collaboratively with NQF to ensure a clear multi-year vision to ensure the most efficient and effective utilization of the HHS contract. The contract with this consensus-based entity, 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 to ensure broad transparency in achieving value in health care delivery.

Over the past year NQF began work on several tasks outlined in the Statement of Work, including: Development of a national strategy for performance measurement and prioritization of measures for development and endorsement; an evaluation of NQF's consensus development process; several measure endorsement projects focused on measure gap areas such as outcomes measures and patient safety measures; maintenance of currently NQF-endorsed measures; promotion of Electronic Health Records through such activities as the development of the "E-measure" and the retooling of a subset of existing NQF-endorsed measures into E-measure format; development of a public website to make available current NQF activities; endorsement of efficiency and resource use measures. 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 the first full performance year of the contract, NQF completed deliverables for each task. HHS will continue to task NQF with single year and multi-year projects.

Formulation of National Strategy and Priorities for Health Care Performance Measurement

During March 2009 to February 2010, NQF created a framework for measurement prioritization by conducting an environmental scan of, at a minimum, the 20 patient conditions that account for over 95% of costs to the Medicare program. NQF established a steering committee to oversee the prioritization process and to consider additional measurement streams (e.g. population health, child health, Health IT) in its prioritization process.

Consensus Development Process for Measure Endorsement

During March 2009 to February 2010, NQF established steering committees to consider endorsement of outcomes measures in 3 phases. The first 2 phases will endorse outcomes measures for patients with Medicare high priority conditions. The third phase will endorse outcomes measures for mental health and for children. Future steps also include the endorsement of measures for patients in Nursing Homes as well as Patient Safety measures.

Maintenance of Consensus Endorsed Measures

During March 2009 to February 2010, NQF maintained endorsed measures relevant to HHS-wide programs and will be maintaining consensus-based endorsed measures as developed under the priority process.

Promotion of Electronic Health Records

During March 2009 to February 2010, NQF supported the promotion of electronic health records as part of HHS-wide efforts. NQF developed the Health Quality Measure Format (HQMF, or "E-measure"), began the retooling process to convert a sub-set of currently endorsed measures into E-Measure format, and supported the HIT Standards Panel in developing code lists and vocabulary standards for the transition to performance measurement through Electronic Health Records. Future steps include the retooling of the remaining subset of currently endorsed measures, the development of a measure authoring tool for creating E-measures, and to support clinical decision support systems for measuring and reporting

performance. NQF will also support the selection of performance measures for the Meaningful Use of electronic health records.

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

During March 2009 to February 2010, NQF supported a variety of performance measurement efforts including, but not limited to, the areas of efficiency, harmonization, outcomes, patient safety, care coordination, ICD-10, palliative care, and nursing home quality metrics.

The public is encouraged to give input through the NQF process and will be able to track the progress on work related to this contract on the NQF Web site located at: <http://www.qualityforum.org/projects/ongoing/hhs/>.

VI. 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: October 15, 2010.

Kathleen Sebelius,
Secretary, Department of Health and Human Services.

[FR Doc. 2010-26795 Filed 10-21-10; 8:45 am]

BILLING CODE 4150-05-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Decision To Evaluate a Petition To Designate a Class of Employees From BWX Technologies Inc., Lynchburg, VA, To Be Included in the Special Exposure Cohort

AGENCY: National Institute for Occupational Safety and Health (NIOSH), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: HHS gives notice as required by 42 CFR 83.12(e) of a decision to evaluate a petition to designate a class of employees from BWX Technologies, Inc., Lynchburg, Virginia, to be included in the Special Exposure Cohort under the Energy Employees Occupational Illness Compensation Program Act of 2000. The initial proposed definition for the class being evaluated, subject to revision as warranted by the evaluation, is as follows: