

care services, specifically any facilitators and barriers. These data will provide the HIV/AIDS Bureau with the background to make informed policies and changes to the Ryan White Program in this new era when the well-being of PLWH demands a more complex and long-term HIV care model.

Likely Respondents: Clinics funded by the Ryan White HIV/AIDS Program.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing

and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

Total Estimated Annualized Burden—Hours

Form name	Number of responses	Number of responses per respondents	Total responses	Average burden per response (in hours)	Total burden hours for all responses
Clinic Director Online Survey	130	1	130	0.5	65
Clinician Online Survey	90	1	90	0.5	45
Data Extraction	30	1	30	4.0	120
Medical Director Interview Guide	30	1	30	0.5	15
Total	280	280	245

Jackie Painter,

Director, Division of the Executive Secretariat.

[FR Doc. 2015-22058 Filed 9-3-15; 8:45 am]

BILLING CODE 4165-15-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Final Effect of Designation of a Class of Employees for Addition to the Special Exposure Cohort

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

ACTION: Notice.

SUMMARY: HHS gives notice concerning the final effect of the HHS decision to designate a class of employees from the Westinghouse Electric Corp. in Bloomfield, New Jersey, as an addition to the Special Exposure Cohort (SEC) under the Energy Employees Occupational Illness Compensation Program Act of 2000.

FOR FURTHER INFORMATION CONTACT: Stuart L. Hinnefeld, Director, Division of Compensation Analysis and Support, NIOSH, 1090 Tusculum Avenue, MS C-46, Cincinnati, OH 45226-1938, Telephone 877-222-7570. Information requests can also be submitted by email to DCAS@CDC.GOV.

SUPPLEMENTARY INFORMATION:

Authority: 42 U.S.C. 7384q(b). 42 U.S.C. 7384l(14)(C).

On July 28, 2015, as provided for under 42 U.S.C. 7384l(14)(C), the Secretary of HHS designated the following class of employees as an addition to the SEC:

All Atomic Weapons Employees who worked at the facility owned by Westinghouse Electric Corp., in Bloomfield, New Jersey, during the period from February 1, 1958, through May 31, 1958, or during the period from June 1, 1959, through June 30, 1959, for a number of work days aggregating at least 250 work days, occurring either solely under this employment, or in combination with work days within the parameters established for one or more other classes of employees included in the Special Exposure Cohort.

This designation became effective on August 27, 2015. Therefore, beginning on August 27, 2015, members of this class of employees, defined as reported in this notice, became members of the SEC.

John Howard,

Director, National Institute for Occupational Safety and Health.

[FR Doc. 2015-22042 Filed 9-3-15; 8:45 am]

BILLING CODE 4163-19P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretarial Review and Publication of the Annual Report to Congress and the Secretary Submitted by the 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 2015 Annual Report to Congress and the Secretary submitted by the consensus-based entity (CBE) in contract with the Secretary as mandated

by section 1890(b)(5) of the Social Security Act, which was created by section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and amended by section 3014 of the Patient Protection and Affordable Care Act of 2010. The statute requires the Secretary to review and 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: Corette Byrd, (410) 786-1158.

The order in which information is presented in this notice is as follows:

- I. Background
- II. The 2015 Annual Report to Congress and the Secretary: "National Quality Forum Report of 2014 Activities to Congress and the Secretary of the Department of Health and Human Services"
- III. Secretarial Comments on the 2015 Annual Report to Congress and the Secretary
- IV. Future Steps
- V. Collection of Information Requirements

I. Background

In recent years we have seen significant improvements in many important dimensions of the quality of the nation's health care. The 2014 National Quality and Disparities Report, published in April 2015 by the Agency for Healthcare Research and Quality and available at <http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/index.html>, shows, for example, significant improvement in the quality of hospital care in 2013, with an estimated 1.3 million fewer harmful conditions acquired by patients while in the hospital and 50,000 fewer deaths

occurred during hospital stays as compared to 2010. However, the Report also indicates that there are many challenges to improving quality in health care across the nation. The Report shows that many patients are still potentially harmed by the care they receive, and only 70 percent of recommended care is received by patients as assessed by a broad array of quality measurements. It also shows that people of low income and racial and ethnicity minorities often receive lesser quality health care.

To address these problems, the Department of Health and Human Services is working to improve the nation's health care delivery system so that the care provided when people are ill is consistently high quality, and that healthy people are helped to stay healthy. Similarly, many States are leveraging their purchasing power to achieve these same ends; and in the private sector, provider organizations, accrediting bodies, foundations, and other non-profit organizations are working to target and align efforts to quicken the pace of improvement.

An essential factor for the success of all these efforts is the accurate, valid, and reliable measurement of the quality (and efficiency) of health care. Recognizing the need for good quality measures, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) created section 1890 of the Social Security Act (the Act), which requires the Secretary of HHS to contract with a consensus-based entity (CBE) to perform multiple duties pertaining to healthcare performance measurement. Section 3011 of the Patient Protection and Affordable Care Act of 2010 (ACA) expanded the activities of the CBE in improving health care quality.

In January of 2009, a competitive contract was awarded by HHS to the National Quality Forum (NQF) to fulfill requirements of section 1890 of the Act. A second, multi-year contract was awarded to NQF again after an open competition in 2012. This contract includes the following duties as mandated by section 1890(b) of the Act:

Priority Setting Process: Formulation of a National Strategy and Priorities for Health Care Performance Measurement. The CBE is to synthesize evidence and convene key stakeholders to make recommendations on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In doing so, the CBE is to give priority to measures that: (a) Address the health care provided to patients with prevalent, high-cost chronic diseases; (b) have the

greatest potential for improving quality, efficiency and patient-centered health care; and (c) may be implemented rapidly due to existing evidence, standards of care or other reasons. Additionally, the CBE must take into account measures that: (a) May assist consumers and patients in making informed health care decisions; (b) address health disparities across groups and areas; and (c) address the continuum of care across multiple providers, practitioners and settings.

Endorsement of Measures: The CBE is to provide for the endorsement of standardized health care performance measures. This process must consider whether measures are evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, responsive to variations in patient characteristics such as health status, language capabilities, race or ethnicity, and income level and are consistent across types of health care providers including hospitals and physicians.

Maintenance of CBE Endorsed Measures. The CBE is required to establish and implement a process to ensure that endorsed measures are updated (or retired if obsolete) as new evidence is developed.

Review and Endorsement of an Episode Grouper Under the Physician Feedback Program. "Episode-based" performance measurement is an approach to better understanding the utilization and costs associated with a certain condition by grouping together all the care related to that condition. "Episode groupers" are software tools that combine data to assess such condition-specific utilization and costs over a defined period of time. The CBE is required to provide for the review, and as appropriate, endorsement of an episode grouper as developed by the Secretary.

Convening Multi-Stakeholder Groups. The CBE must convene multi-stakeholder groups to provide input on: (1) The selection of certain categories of quality and efficiency measures, from among such measures that have been endorsed by the entity; and such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and (2) national priorities for improvement in population health and in the delivery of health care services for consideration under the national strategy. The CBE provides input on measures for use in certain specific Medicare programs, for use in programs that report performance

information to the public, and for use in health care programs that are not included under the Social Security Act. The multi-stakeholder groups provide input on measures to be implemented through the federal rulemaking process for various federal health care quality reporting and quality improvement programs including those that address certain Medicare services provided through hospices, hospital inpatient and outpatient facilities, physician offices, cancer hospitals, end stage renal disease (ESRD) facilities, inpatient rehabilitation facilities, long-term care hospitals, psychiatric hospitals, and home health care programs.

Transmission of Multi-Stakeholder Input. Not later than February 1 of each year, the CBE is to transmit to the Secretary the input of multi-stakeholder groups.

Annual Report to Congress and the Secretary. Not later than March 1 of each year the CBE is required to submit to Congress and the Secretary of HHS an annual report. The report is to describe:

(i) The implementation of quality and efficiency measurement initiatives and the coordination of such initiatives with quality and efficiency initiatives implemented by other payers;

(ii) recommendations on an integrated national strategy and priorities for health care performance measurement;

(iii) performance of the CBE's duties required under its contract with HHS;

(iv) gaps in endorsed quality and efficiency measures, including measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act (National Quality Strategy), and where quality and efficiency measures are unavailable or inadequate to identify or address such gaps;

(v) areas in which evidence is insufficient to support endorsement of quality and efficiency measures in priority areas identified by the Secretary under the National Quality Strategy, and where targeted research may address such gaps; and

(vi) the convening of multi-stakeholder groups to provide input on: (1) The selection of quality and efficiency measures from among such measures that have been endorsed by the CBE and such measures that have not been considered for endorsement by the CBE but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and (2) national priorities for improvement in population health and the delivery of health care services for consideration under the National Quality Strategy.

The statutory requirements for the CBE to annually report to Congress and the Secretary of HHS also specify that the Secretary of HHS must review and publish the CBE's annual report in the **Federal Register**, together with any comments of the Secretary on the report, not later than six months after receiving it.

This **Federal Register** notice complies with the statutory requirement for Secretarial review and publication of the CBE's annual report. NQF submitted a report on its 2014 activities to the Secretary on February 25, 2015. This 2015 annual report to Congress and the Secretary of the Department of Health and Human Services (dated March 1, 2015) is presented below in Section II. Comments of the Secretary on this report are presented below in section III.

II. The 2015 Annual Report to Congress and the Secretary: "NQF Report of 2014 Activities to Congress and the Secretary of the Department of Health and Human Services"

NQF Report on 2014 Activities to Congress and the Secretary of the Department of Health and Human Services

I. Executive Summary

Over the last seven years, Congress has passed two statutes with several extensions that call upon the Department of Health and Human Services (HHS) to work with a consensus-based entity (the "Entity") to facilitate multistakeholder input into (1) setting national priorities for improvement in population health and quality, and (2) recommending use of quality and efficiency measures. The first of these statutes is the 2008 Medicare Improvements for Patients and Providers Act (MIPPA) (PL 110-275), which established the responsibilities of the consensus-based entity by creating section 1890 of the Social Security Act. The second statute is the 2010 Patient Protection and Affordable Care Act (ACA) (PL 111-148), which modified and added to the consensus-based entity's responsibilities. The American Taxpayer Relief Act of 2012 (PL 112-240) extended funding under the MIPPA statute to the consensus-based entity through fiscal year 2013. The Protecting Access to Medicare Act of 2014 (PL 113-93) extended funding under the MIPPA and ACA statutes to the consensus-based entity through March 31, 2015. HHS has awarded contracts to the consensus-based entity identified in the statute which is currently the National Quality Forum (NQF).

These laws specifically charge the Entity to report annually on its work:

As amended by the above laws, the Social Security Act (the Act)—specifically section 1890(b)(5)(A)—also mandates that the entity report to Congress and the Secretary of HHS no later than March 1st of each year. The report must include descriptions of: (1) How NQF has implemented quality and efficiency measurement initiatives under the Act and coordinated these initiatives with those implemented by other payers; (2) NQF's recommendations with respect to activities conducted under the Act; (3) NQF's performance of the duties required under its contract with HHS; (4) gaps in endorsed quality and efficiency measures, including measures that are within priority areas identified by the Secretary under HHS' National Quality Strategy; (5) areas in which evidence is insufficient to support endorsement of quality and efficiency measures in priority areas identified by the National Quality Strategy, and where targeted research may address such gaps; and (6) the matters described in clauses (i) and (ii) of paragraph (7)(A) of section 1890(b).¹

This sixth Annual Report highlights NQF's work conducted between January 1, 2014 and December 31, 2014 related to these statutes and conducted under contract with HHS. The deliverables produced under contract in 2014 are referenced throughout this report, and a full list is included in Appendix A.

In addition to NQF's statutorily mandated work, NQF worked with federal partners such as the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) in 2014 on a lean improvement project in order to streamline its endorsement processes. Also in 2014, NQF began to work with CMS and private insurers to further the uniform use of measures (commonly referred to as alignment) between the public and private sectors. Both of these initiatives were funded by NQF without the support of federal funds.

Recommendations on the National Quality Strategy and Priorities

Section 1890(b)(1) of the Social Security Act (the Act), mandates that the consensus-based entity (CBE) also required under section 1890 of the Act shall "synthesize evidence and convene key stakeholders to make recommendations . . . on an integrated national strategy and priorities for healthcare performance measurement in all applicable settings." In making such recommendations, the entity shall ensure that priority is given to measures that address the healthcare provided to

patients with prevalent, high-cost chronic diseases, that focus on the greatest potential for improving the quality, efficiency, and patient-centeredness of healthcare, and that may be implemented rapidly due to existing evidence and standards of care, or other reasons. In addition, the entity will take into account measures that may assist consumers and patients in making informed healthcare decisions, address health disparities across groups and areas, and address the continuum of care a patient receives, including services furnished by multiple healthcare providers or practitioners and across multiple settings.

In 2010, at the request of the Department of Health and Human Services (HHS), the NQF-convened National Priorities Partnership (NPP) provided input that helped shape the initial version of the *National Quality Strategy (NQS)*.² The NQS was released in March 2011, setting forth a cohesive roadmap for achieving better, more affordable care, and better health. Upon the release of the NQS, HHS accentuated the word 'national' in its title, emphasizing that healthcare stakeholders across the country, both public and private, all play a role in making the NQS a success.

NQF has continued to further the NQS by convening diverse stakeholder groups to reach consensus on key strategies for improvement. In 2014, NQF completed work in several emerging areas of importance that address the National Quality Strategy, such as how to improve population health within communities; how to organize measures and other meaningful information to help consumers make informed healthcare decisions in the federal exchange marketplace; and how to dramatically improve patient safety in high-priority areas such as maternity care, avoidable readmissions, and patient- and family-centered engagement. NQF also continued its work in support of the Common Formats, which helps standardize electronic reporting of patient safety event data.

Quality and Efficiency Measurement Initiatives (Performance Measures)

Under section 1890(b)(2) and (3) of the Act, the entity must provide for the endorsement of standardized healthcare performance measures. The endorsement process shall consider whether measures are evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible for collecting and reporting data, responsive to variations in patient

characteristics, and consistent across healthcare providers. In addition, the entity must maintain endorsed measures, including updating endorsed measures or retiring obsolete measures as new evidence is developed.

Since its inception in 1999, NQF has developed a portfolio that covers many aspects of measurement and currently contains approximately 600 measures which are in widespread use across an array of settings. About 300 NQF-endorsed measures are used in more than 20 federal public reporting and pay-for-performance programs; these and other measures are also used in private sector and state programs.

Over the past several years, NQF in partnership with HHS and private-sector stakeholders has worked to evolve the science of performance measurement. This effort has included placing greater emphasis on both evidence behind a measure and ensuring a clear link to outcomes; a focus on addressing key measurement gaps, including measures related to care coordination and patient experience; and implementation of a requirement that testing of measures demonstrate their reliability and validity. In addition, NQF has moved from convening experts for the duration of a project to using standing committees to be able to respond in real time to newly published research to ensure its endorsed measures are accurate, evidence-based, and meaningful.

NQF also has laid the foundation for the next generation of measures by providing guidance on criteria to evaluate episode groupers, as well as how and when to incorporate socioeconomic (SES) and sociodemographic factors in measurement. Beginning in January 2015, NQF will undertake a two year trial period during which measure developers will be invited to submit measures that take into account socioeconomic and sociodemographic factors where appropriate. These measures would be eligible for NQF endorsement and are required to include the non-risk-adjusted, stratified, and socioeconomically adjusted measures. This trial period will enable the field to compare measures which are adjusted and not adjusted for SES and to consider the implications of adjustment. When the trial period is over, NQF will determine if its endorsement criteria should be permanently changed to include SES adjustment where appropriate.

Across six HHS-funded projects in 2014, NQF added 98 measures to its portfolio. Forty-eight of these measures were new measure submissions, and 50

were measures that retained their NQF endorsement. Twenty-seven of the 98 endorsed measures are outcome measures, 59 are process measures, 7 are composite measures, 2 are structural measures, and 3 are cost and resource use measures.

In 2014, NQF endorsed measures in order to:

Drive the system to be more responsive to patient/family needs—In 2014, this effort included Person- and Family-Centered Care and Care Coordination endorsement projects, including patient-reported outcomes and patient experience surveys. These measures are used in programs such as the Hospital Inpatient Quality Reporting (IQR) Program and Physician Quality Reporting System (PQRS) and are also reported on the Hospital Compare Web site.

Improve care for highly prevalent conditions—NQF's work included Cardiovascular, Endocrine, and Musculoskeletal endorsement projects in 2014. NQF-endorsed measures in these areas are used in the Hospital IQR Program and PQRS.

Emphasize cross-cutting areas to foster better care and coordination—In 2014, this effort included Behavioral Health and Patient Safety endorsement projects. NQF-endorsed measures in these areas are used in the Home Health Quality Reporting Program, Hospital IQR Program, the Inpatient Psychiatric Facility Quality Reporting Program, and PQRS.

Support new accountability efforts coming online—NQF's work included Cost/Resource Use and Readmission endorsement projects. For example, the NQF-endorsed readmissions measures are used in CMS' Hospital Readmissions Reduction Program and Physician Value-Based Payment Modifier Program.

During 2014, NQF also removed 93 measures from its portfolio for a variety of reasons: Measures no longer met endorsement criteria; measures were harmonized with other similar, competing measures; measure developers chose to retire measures they no longer wished to maintain; a better, substitute measure was submitted; or measures "topped out," with providers consistently performing at the highest level. Consistently culling the portfolio through these means and through the measure maintenance process ensures that the NQF portfolio is relevant to the most current practices in the field.

In September 2014, HHS awarded NQF additional measure endorsement projects, addressing topics such as eye, ear, nose, and throat conditions; renal, surgery, and cardiovascular conditions; and patient safety. NQF has begun work

on these projects by issuing calls for measures to be reviewed and considered for endorsement.

Stakeholder Recommendations on Quality and Efficiency Measures and National Priorities

Under section 1890A of the Act, HHS is required to establish a pre-rulemaking process under which a consensus-based entity (currently NQF) would convene multistakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures for use in certain federal programs. The list of quality and efficiency measures HHS is considering for selection is to be publicly published no later than December 1 of each year. No later than February 1 of each year, the consensus-based entity (NQF) is to report to HHS the input of the multistakeholder groups, which will be considered by HHS in the selection of quality and efficiency measures.

The Measure Applications Partnership (MAP) is a public-private partnership convened by NQF to provide input to HHS on the selection of performance measures for more than 20 federal public reporting and performance-based payment programs. MAP brings together approximately 150 healthcare leaders and experts representing nearly 90 private-sector organizations as well as federal liaisons from 7 different agencies for an intensive annual review of measures being considered by HHS. HHS then takes these recommendations under consideration as it develops and updates the regulations that govern these programs.

In 2014, HHS requested that MAP review measures for 20 federal public reporting and payment programs. MAP's work fosters use of a more uniform set of measures across federal programs and across the public and private sectors. This uniformity—commonly referred to as alignment—helps providers better identify key areas in which to improve quality; reduces wasteful data collection for hospitals, physicians, and nurses; and helps to curb the proliferation of redundant measures which could confuse patients and payers.

MAP also developed "families of measures" (groups of measures selected to work together across settings of care in pursuit of specific healthcare improvement goals) for the high-priority areas of affordability, population health, and person- and family-centered care; and provided input on measures for vulnerable populations, including Medicare-Medicaid enrollees and adults and children enrolled in Medicaid.

Gaps in Endorsed Quality and Efficiency Measures and Evidence and Targeted Research Needs

Under section 1890(b)(5)(iv) of the Act, the entity is required to describe gaps in endorsed quality and efficiency measures, including measures within priority areas identified by HHS under the agency's National Quality Strategy, and where quality and efficiency measures are unavailable or inadequate to identify or address such gaps. Under section 1890(b)(5)(v) of the Act, the entity is also required to describe areas in which evidence is insufficient to support endorsement of quality and efficiency measures in priority areas identified by the Secretary under the National Quality Strategy and where targeted research may address such gaps.

NQF continued in 2014 its efforts to fill measurement gaps—areas where there is a need for performance measures—by building on and supplementing the analytic work that informed previous Measure Gap Analysis Reports.³ Through both the MAP and performance measurement projects, NQF took initial steps to encourage gap-filling by identifying areas in which no adequate measures exist, offering more detailed suggestions for measure development, and involving measure developers in discussions about gaps.

In an effort to provide more detailed recommendations in key measurement gap areas, HHS requested in 2013 that NQF convene multistakeholder committees to recommend priorities for performance measurement development across five topics areas that corresponded to important aspects of the National Quality Strategy, including:

- Adult Immunization—identifying critical areas for performance measurement to optimize vaccination rates and outcomes across adult populations;
- Alzheimer's Disease and Related Dementias—targeting a high-impact condition with complex medical and social implications that impact patients, their families, and their caregivers;
- Care Coordination—focusing on team-based care and coordination between providers of primary care and community-based services in the context of the “health neighborhood”;
- Health Workforce—emphasizing the role of the workforce in prevention and care coordination, linkages between healthcare and community-based services, and workforce deployment; and
- Person-Centered Care and Outcomes—considering measures that

are most important to patients—particularly patient-reported outcomes—and how to advance them through health information technology.

Several important conclusions have been drawn from NQF's 2014 work in the gaps space. MAP reported in its 2014 pre-rulemaking review⁴ of proposed measures that the topic areas that need measures were largely the same as from the previous year. Those gaps are in safety, patient and family engagement, healthy living, care coordination, affordability, and prevention and treatment of leading causes of mortality. Measure development in these areas should be a priority. NQF's efforts to define in more detail measures needed in these and other areas may help fill these gaps in the future. NQF is also exploring efforts in partnering with other organizations to address persistent measure gaps.

II. Recommendations on the National Quality Strategy and Priorities

Section 1890(b)(1) of the Social Security Act (the Act), mandates that the consensus-based entity (CBE) also required under section 1890 of the Act shall “synthesize evidence and convene key stakeholders to make recommendations . . . on an integrated national strategy and priorities for healthcare performance measurement in all applicable settings.” In making such recommendations, the entity shall ensure that priority is given to measures:

- 1) That address the health care provided to patients with prevalent, high-cost chronic diseases;
- 2) with the greatest potential for improving the quality, efficiency, and patient-centeredness of healthcare; and
- 3) that may be implemented rapidly due to existing evidence, standards of care, or other reasons. In addition, the entity will take into account measures that: 1) May assist consumers and patients in making informed healthcare decisions; 2) address health disparities across groups and areas; and 3) address the continuum of care a patient receives, including services furnished by multiple healthcare providers or practitioners and across multiple settings.

In 2010, at the request of HHS, the NQF-convened National Priorities Partnership (NPP) provided input that helped shape the initial version of the *National Quality Strategy (NQS)*. The NQS was released in March 2011, setting forth a cohesive roadmap for achieving better, more affordable care, and better health. Upon the release of the NQS, HHS accentuated the word ‘national’ in its title, emphasizing that healthcare stakeholders across the

country, both public and private, all play a role in making the NQS a success.

NQF has continued to further the NQS by convening diverse stakeholder groups to reach consensus on key strategies for improvement. In 2014, NQF began or completed work in several emerging areas of importance that address the National Quality Strategy, such as how to improve population health within communities; providing advice to CMS on what information on healthcare quality is available to make informed healthcare coverage decisions through the Federal Health Insurance Marketplace; how to dramatically improve patient safety in high-priority areas through the use of Action Teams focusing on maternity care, avoidable readmissions, and patient and family engagement; and working with AHRQ to develop Common Formats for patient safety data reporting. Accomplishments in these areas in 2014 are described below.

Improving Population Health Within Communities

The National Quality Strategy's population health aim focuses on:

“Improv[ing] the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.”

One of the NQS' six priorities specifically emphasizes:

“Working with communities to promote wide use of best practices to enable healthy living.”

With the expansion of coverage due to the ACA, the federal government has an opportunity to meaningfully coordinate its improvement efforts with those of local communities in order to better integrate and align medical care and population health. Such efforts can help improve the nation's health and lower costs.

To support these efforts, NQF is conducting a multiphase project focused on helping communities implement population health initiatives. In August 2014, NQF produced “The Guide for Community Action” handbook. With funding from HHS, NQF brought together a multistakeholder committee to develop this Guide through an open and iterative process. The Committee included population and community health experts, public health practitioners, healthcare providers, coordinators of home and community based services, consumer advocates, employers, and others who influence population health.

To inform creation of the Guide, an Advisory Group consisting of a smaller

subset of the full Committee was convened to do an environmental scan at the start of the project. Additional input was provided by the full Committee, federal partners engaged in the work, and from the Government Task Lead (GTL) overseeing this project.

The Guide⁵ was created to be used by anyone who wants to improve health across a population, whether locally, in a broader region or state, or even nationally. The Guide’s purpose is to support individuals and groups working together at all levels to successfully promote and improve population health

over time. It contains brief summaries of 10 elements important to consider during community-based efforts, along with actions to take and examples of practical resources, to build a coalition that can improve population health. The 10 elements are summarized below:

Element	Examples of questions to ask
Self-assessment about readiness to engage in this work	What types of assessments have already been done in efforts to improve the health of this population?
Leadership across the region and within organizations	Which individuals or organizations in the region are recognized or potential leaders in population health improvement?
Organizational planning and priority-setting process	Which organizations in the region engage in collaborative planning and priority setting to guide activities to improve health in the region?
Community health needs assessment and asset mapping process	Which organizations in the region already conduct community health needs assessments or asset mapping regarding population health?
An agreed-upon, prioritized set of health improvement activities	What are the focus areas of existing population health improvement projects or programs, if any?
Selection and use of measures and performance targets	Which measures, metrics, or indicators are already being used to assess population health in the region, if any?
Audience-specific strategic communication	What is the level of skill or capability to engage in effective communication with each of the key audiences in the region?
Joint reporting on progress toward achieving intended results	Which organizations in the region publicly or privately report on progress in improving population health?
Indications of scalability	For current or new population health work in the region, what is the potential for expansion into additional groups or other regions?
Plan for sustainability	What new policy directions, structural changes, or specific resources in the region may be useful for sustaining population health improvement efforts over time?

Upon release of the Guide, NQF launched phase 2 of the project. During this phase, NQF began enlisting 10 communities to field test the Action Guide developed in phase 1 of the project. These 10 communities, selected in November 2014, represent a diverse set of groups, each with different levels of experience, varied geographic and demographic focus, and demonstrated involvement in or plans to establish population health-focused programs. The groups selected for the 18-month field test will be participating in a variety of activities, such as applying the content of the Guide to new or existing population health improvement projects, determining what works and what needs enhancement, and offering examples and ideas for revised or new content based on their own experiences. The selected groups also will have the opportunity to interact with one another and with members of the committee through in-person meetings and monthly conference calls.

The 10 field testing groups include:

1. Colorado Department of Health Care Policy and Financing (HCPF), Denver, CO
2. Community Service Council of Tulsa, Tulsa, OK
3. Designing a Strong and Healthy NY (DASH-NY), New York, NY
4. Empire Health Foundation, Spokane, WA

5. Kanawha Coalition for Community Health Improvement, Charleston, WV
6. Mercy Medical Center and Abbe Center for Community Mental Health—A Community Partnership with Geneva Tower, Cedar Rapids, IA
7. Michigan Health Improvement Alliance, Central Michigan
8. Oberlin Community Services and The Institute for eHealth Equity, Oberlin, OH
9. Trenton Health Team, Inc., Trenton, NJ
10. The University of Chicago Medicine Population Health Management Transformation, Chicago, IL

Health Insurance Marketplaces Quality Rating System

Under the statutory provision that the consensus-based entity will “take into account measures that may assist consumers and patients in making informed healthcare decisions,” HHS directed NQF to convene multistakeholder groups to provide input and comment on the proposed quality and efficiency measures that will form a core measure set, the hierarchical structure, and organization of a Quality Rating System (QRS). The measures will help consumers select health plans through the new Health Insurance Marketplaces established by the Affordable Care Act.

NQF’s Measure Applications Partnership (MAP) carried out this project. MAP is made up of stakeholders from a wide array of healthcare sectors and 7 federal agencies, as well as 150 subject matter experts representing nearly 90 private-sector organizations, tasked with recommending measures for federal public reporting, payment, and other programs to enhance healthcare value.

In the final deliverable for this project, the report titled *Input on the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces*,⁶ MAP recognized that the initial implementation of the QRS will be limited to existing, developed measures at the health plan level and identified four primary steps to moving forward over the next five years:

- First, HHS should immediately begin to address areas that are important to consumers but are not represented across the existing measures in the QRS, specifically, out-of-pocket costs and shared decisionmaking.
- Second, HHS should thoroughly test all aspects of the QRS with diverse marketplace populations without delaying implementation and monitor on an ongoing basis.
- Third, HHS should include provider-level quality information within three years after initial

implementation for comprehensive support of consumer decisionmaking.

- Fourth, HHS should add functionality to the QRS within five years of initial implementation that allows consumers to customize and prioritize information to assist in their unique decisionmaking processes.

MAP considered HHS' proposed measures and structure for the marketplace that will be implemented in 2016 within the context of the broader vision bulleted above. MAP supported 28 out of 42 measures proposed for the family core set and 19 out of 25 measures proposed for the child core set. Additionally, MAP conditionally supported eight measures for the family core set and four for the child core set, and did not support six measures for the family core set and two for the child core set. The recommended measures span a wide range of areas including CAHPS surveys for various topics, preventative care measures, resource use measures, readmissions measures, prenatal care, diabetes measures and other measures that address prevalent conditions. Recognizing that the proposed measures are limited to those currently available, MAP identified three measures to address gap areas, and prioritized gap areas for measure development. The specific measures proposed by HHS and MAP's recommendations are listed in Appendix G of the report.

Improving Patient Safety in High-Priority Areas

NQF is leveraging its membership of over 400 organizations from every part of the healthcare system and its relationships with key stakeholders across the healthcare field to further mobilize private sector action in support of HHS' *Partnership for Patients*,⁷ an initiative started in spring 2011 to improve patient safety across the country. Specifically, in 2013 NQF formed three Action Teams—multistakeholder teams tasked with developing and acting on specific goals aligned with the NQS safety priority—to address high-priority areas for improvement, including maternity care, patient and family engagement, and readmissions. This work concluded in 2014.

The Action Teams comprised diverse national organizations that have members or chapters in communities across the country. Through coordination at the national level, Action Teams spur changes to the delivery system at the local level. These Teams were committed to specific goals, including:

- Reducing early elective deliveries (EEDs);
- Reducing readmissions for complex and vulnerable populations; and
- Engaging patients and families in health system improvement.

The Action Teams developed Action Pathway Reports and other tools as resources for those who wish to learn from the challenges and successes of the Action Teams.

Additionally in 2014, NQF held four quarterly meetings and developed four impact reports that called out innovative ideas and best practices that have the potential to accelerate change in the area of patient safety. These meetings focused on specific drivers for safety, including strengthening the workforce, accreditation and certification, purchasing and payment, and patient and family engagement. Quarterly impact reports provided a synopsis of Action Team and stakeholder activities as well as the quarterly meetings. The accomplishments of each of the three Action Teams are described below.

Maternity Action Team

The Maternity Action Team was reconvened in early 2014 to continue its work on addressing inappropriate maternity care. Although significant progress has been made in reducing EEDs, there are many areas of the country that are still finding it difficult to achieve results. As described in the Action Team's report, *Maternity Action Team Action Pathway: Promoting Healthy Mothers and Babies*,⁸ the overarching goal of the Action Team was to reduce EEDs prior to 39 weeks gestation to 5 percent or less in every state. To support this goal, three specific strategies were identified: Measurement, partnership, and consumer and provider engagement.

The Action Team developed and disseminated a *Playbook for the Successful Elimination of Early Elective Deliveries*⁹ in August 2014 to provide guidance and strategies to help those still struggling to reduce their rates of EEDs.

Readmissions Action Team

The Readmissions Action Team was formed to support the Partnership for Patients goal of reducing hospital readmissions within 30 days by 20 percent on a national level. As described in the *Readmissions Action Team Action Pathway: Reducing Avoidable Admissions and Readmissions*¹⁰ report, the focus of this team was to achieve the Partnership for Patients goals by identifying high-risk patients with psychosocial needs, and

leveraging patient, provider, and community partnership to address those needs so as to prevent unwarranted readmissions. Strategies identified by the Action Team include working together across stakeholder groups to enhance systems improvement, collaboration among providers, and patient and family engagement. The Action Team shared best practices and approaches to improving the quality of care for high-risk populations to foster both individual and collective efforts to further progress.

Patient and Family Engagement Action Team

The Patient and Family Engagement Action Team supports the Partnership for Patients goals around patient safety by utilizing the support of patients and families to be patient safety advocates, and by partnering with healthcare organizations to encourage person-centered care as an organizational core value. As described in the Team's *Patient and Family Engagement Action Pathway: Fostering Authentic Partnerships between Patients, Families, and Care Teams*¹¹ report, three strategies were used to support the goal of fostering authentic partnerships: Identifying tools, resources, and practices that reflect patient-preferred practices, and encourage meaningful dialogue among providers; leveraging existing networks and relationships to spread these tools and practices; and activating patients and families to participate in organizational redesign and governance to drive system-level change.

In support of the strategy to identify tools that can foster dialogue between patients and caregivers, the Action Team created and promoted the use of a *Patient Passport*, a tool to assist patients in having meaningful and effective communication with providers, particularly in the hospital setting. The tool allows patients to initiate and guide conversations with their providers, with the added benefit of making frontline staff's work simpler by presenting to them information about the patient that is concise and meaningful.

Common Formats for Patient Safety Data

For more than 10 years, both NQF and the Agency for Healthcare Research and Quality (AHRQ) have developed and promulgated standardized approaches for reporting and reducing adverse safety events to enable shared learning across the country. NQF's list of Serious Reportable Events (SREs), first published in 2002, has helped raise awareness and stimulate action around

preventable adverse events that should be publicly reported. The Patient Safety and Quality Improvement Act of 2005 advanced reporting further by authorizing the development of common and consistent definitions and standardized formats to collect, collate, and analyze patient safety events occurring within and across healthcare providers. AHRQ developed the Common Formats—a standardized method for collection and compilation of information about patient safety events occurring in the United States, including Serious Reportable Events—to help operationalize the Act.

To ensure the Common Formats are feasible for use in the field, AHRQ has contracted with NQF to implement a process that ensures broad stakeholder input on new Common Formats modules developed by AHRQ for both hospitals and nursing homes.

NQF has established a process and tools for receiving comments on the Common Formats beginning with the release of each set and version and continuing for a specified period thereafter. This project is guided by an NQF-convened Expert Panel that considers and makes recommendations regarding comments from healthcare stakeholders. Previously, based upon the Expert Panel's recommendations, NQF supported AHRQ in its iterative revisions and refinements of Common Formats for hospitals and nursing homes. AHRQ has now developed Common Formats for surveillance in hospitals.

In 2014, NQF continued to collect comments on all versions of Common Formats for Event Reporting—Hospital, Common Formats for Event Reporting—Nursing Home V.0.1 Beta, and for individual modules that have been integrated into these sets. NQF continues to collect comments on Hospital V.1.1 and V.1.2 and Nursing Home V.0.1 Beta. All comments received in 2014 have been acted upon by the Expert Panel and recommendations have been provided to AHRQ. Future expansions of the Common Formats will include patient events in ambulatory settings.

III. Quality and Efficiency Measurement Initiatives (Performance Measures)

Under section 1890(b)(2) and (3) of the Act, the entity must provide for the endorsement of standardized health care performance measures. The endorsement process shall consider whether measures are evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible for collecting and reporting data,

responsive to variations in patient characteristics, and consistent across types of healthcare providers. In addition, the entity must maintain endorsed measures by ensuring that such measures are updated, or retired, as new evidence is developed.

Standardized healthcare performance measures are used by a range of healthcare stakeholders for a variety of purposes. Measures help clinicians, hospitals, and other providers understand whether the care they provide their patients is optimal and appropriate, and if not, where to focus their efforts to improve. In addition, performance measures are increasingly used in federal accountability pay for reporting and payment programs, to inform patient choice, and to assess the effects of care delivery changes.

Working with multistakeholder committees to build consensus, NQF reviews and endorses healthcare performance measures. Since its inception in 1999, NQF has developed a portfolio of approximately 600 NQF-endorsed measures which are in widespread use across an array of settings. The federal government, states, and private sector organizations use NQF's endorsed measures to evaluate performance and share information with patients and their families. Together, NQF measures serve to enhance healthcare value by ensuring that consistent, high-quality performance information and data are available, which allows for comparisons across providers and the ability to benchmark performance.

Over the past several years, NQF, in partnership with HHS and others, has worked to evolve the science of performance measurement. This effort has included placing greater emphasis on evidence and requiring a clear link to outcomes; a greater focus on addressing key gaps in care, including care coordination and patient experience; and a requirement that testing of measures demonstrates their reliability and validity. In addition, in 2014 NQF moved to using standing committees to be able to respond in real time to newly published research to ensure its endorsed measures are accurate, evidence-based, and meaningful.

In 2014, NQF also laid the foundation for the next generation of measures by providing guidance on how to address socioeconomic and sociodemographic factors related to measurement;¹² criteria to use in evaluating episode groupers;¹³ and beginning a project on how to use measures to evaluate performance for rural and low-volume providers.

Current State of NQF Measures Portfolio: Responding to Evolving Needs

Across 6 HHS-funded projects in 2014, NQF added 98 measures to its portfolio. This contrasts with 27 measures endorsed in 2013 across 6 HHS-funded projects. The difference in endorsed measures between 2013 and 2014 can be attributed to the fact that the 2013 work was primarily conducted within a contract that was nearing completion due to a delay in funding. New measure endorsement projects for 2014 were awarded under a new contracting vehicle implemented in September 2013.

NQF ensures that the measure portfolio contains “best-in-class” measures across a variety of clinical and cross-cutting topic areas. Expert committees review both previously endorsed and new measures in a particular topic area to determine which measures deserve to be endorsed or re-endorsed because they are best-in-class. Working with expert multistakeholder committees,¹⁴ NQF undertakes actions to keep its endorsed measure portfolio relevant.

During 2014, NQF also removed 93 measures from its portfolio. NQF removed about 90 measures from its portfolio in 2013. NQF removes measures for a variety of reasons including: measures no longer met more rigorous endorsement criteria; measures are harmonized with other similar, competing measures; measure developers chose to retire measures they no longer wish to maintain; or measures are “topped-out.”

These “topped-out” measures are put into reserve because they show consistently high levels of performance and are therefore no longer meaningful in differentiating performance across providers. This culling of measures ensures that time is spent measuring aspects of care in need of improvement rather than retaining measures related to areas where widespread success has already been achieved.

While NQF pursues strategies to make its measure portfolio appropriately lean and responsive to real-time changes in clinical evidence, it also aggressively seeks measures from the field that will help to fill known measure gaps and to align with the NQS goals. Several important factors motivate NQF to expand its portfolio, including the need for eMeasures; measures that are applicable to multiple clinical specialties and settings of care; measures which assist in the evaluation of new payment models (e.g., bundled payment, Accountable Care Organizations, etc.); and the need for

more advanced measures that help close cross-cutting gaps in areas such as care coordination and patient-reported outcomes.

Finally, NQF also works with stewards and developers who create measures, in order to harmonize related or near-identical measures and eliminate nuanced differences. Harmonization is critical to reducing measurement burden for providers, who may be inundated with requests to report near-identical measures. Successful harmonization results in fewer endorsed measures for providers to report and for payers and consumers to interpret. Where appropriate, NQF works with measure developers to replace existing process measures with more meaningful outcome measures.

Measure Endorsement Accomplishments

As mentioned previously, NQF added 98 measures to its portfolio in 2014. Forty-eight of these measures were new measure submissions and 50 were measures that retained their NQF endorsement. Twenty-seven of the 98 endorsed measures are outcome measures, 59 are process measures, 7 are composite measures, 2 are structural measures, and 3 are cost and resource use measures.

In 2014, NQF endorsed measures in order to:

Drive the system to be more responsive to patient/family needs—In 2014, NQF conducted work on Person- and Family-Centered Care and Care Coordination endorsement projects, including patient-reported outcomes and patient experience surveys. These measures are used in programs such as Hospital Inpatient Quality Reporting (IQR) Program, and the Physician Quality Reporting System (PQRS) as well as reported on the Hospital Compare Web site.

Improve care for highly prevalent conditions—In 2014, NQF conducted work on Cardiovascular, Endocrine, and Musculoskeletal endorsement projects. NQF-endorsed measures in these areas are used in the Hospital IQR Program and PQRS.

Foster better care and coordination by focusing on crosscutting areas—NQF also conducted work on Behavioral Health and Patient Safety endorsement projects in 2014. NQF-endorsed measures in these areas are used in the Home Health Quality Reporting Program, Hospital IQR Program, the Inpatient Psychiatric Facility Quality Reporting Program, and PQRS.

Support new accountability efforts coming online—In 2014, NQF conducted work on Cost/Resource Use

and Readmission endorsement projects. For example, the NQF-endorsed readmissions measures are used in CMS' Hospital Readmissions Reduction Program and Physician Value-Based Payment Modifier Program.

Other project work also began in 2014 on topics such as health and well-being, patient safety, musculoskeletal, person- and family-centered care, and surgery.

Measure highlights in 2014 include the following:

Behavioral health measures. In the United States, it is estimated that approximately 26.4 percent of the population suffers from a diagnosable mental disorder. These disorders—which can include serious mental illnesses, substance use disorders, and depression—are associated with poor health outcomes, increased costs, and premature death. Although general behavioral health disorders are widespread, the burden of serious mental illness is concentrated in about six percent of the population. In 2005, an estimated \$113 billion was spent on mental health treatment in the United States. Of that amount, \$22 billion was spent on substance abuse treatment alone, making substance abuse one of the most costly (and treatable) illnesses in the nation. In 2014, phase 2 of this project was completed and phase 3 is in progress. During phase 2 of the project, the Behavioral Health Steering Committee evaluated 13 new measures and 11 measures undergoing maintenance review of which 20 measures were ratified for endorsement.

In phase 3 of this project, which is currently ongoing, the Behavioral Health Standing Committee reviewed 13 new measures and 6 measures undergoing maintenance review. The Committee recommended 13 measures for endorsement (9 process measures, 3 outcome measures, and 1 composite measure were approved); 1 measure was not recommended; and 1 measure was deferred.

Cost and resource use measures. To expand NQF's portfolio of measures that could be used to assess efficiency and contribute to an assessment of value, NQF has undertaken foundational work on cost and resource use definitions. Phases 2 and 3 of this project were conducted in 2014.

Phase 2 focused on cardiovascular condition-specific measures; phase 3 focused on pulmonary condition-specific measures, and condition-specific episode based measures. The Cost and Resource Use Standing Committee reviewed three measures, and three were recommended for endorsement. In phase 2, three measures were ratified for endorsement; 2 out of

the 3 measures received endorsement only with conditions. The conditions include a one-year look-back assessment of unintended consequences by reviewing the related data, as well as consideration for the SES trial period.

In phase 3, all three recommended measures were ratified in December 2014 with the same conditions as the phase 2 measures: one-year look-back assessment of unintended consequences, consideration for the SES trial period and attribution.

Cardiovascular measures.

Cardiovascular disease is the leading cause of death for men and women in the United States. It accounts for approximately \$312.6 billion in healthcare expenditures annually. Coronary heart disease (CHD), the most common type, accounts for 1 of every 6 deaths in the United States. Hypertension—a major risk factor for heart disease, stroke, and kidney disease—affects 1 in 3 Americans, with an estimated annual cost of \$156 billion in medical costs, lost productivity, and premature deaths.

In Phase 1 of the Cardiovascular project, the Standing Committee evaluated 8 new measures and 9 measures undergoing maintenance review against NQF's standard measure evaluation criteria. 14 (6 process measures, 5 outcome measures and 3 composite measures) of the 17 measures submitted were recommended by the Committee, while 3 were not recommended.

The second phase began in September 2014. Within this phase, the Standing Committee will provide recommendations for endorsement on 16 measures (10 new measures and 6 measures undergoing maintenance review) against NQF's measure evaluation criteria. The final technical report for this phase will be posted on the NQF Cardiovascular phase 2 Web page and submitted to HHS in July 2015.

As part of NQF's ongoing work with performance measurement for cardiovascular conditions, an open call for measures is now underway for the third phase of this project. Within this project, NQF is soliciting new measures and concepts on any cardiovascular condition, including hypertension, coronary artery disease, acute myocardial infarction, PCI, heart failure, atrial fibrillation, or any other heart disease, and any treatments, diagnostic studies, interventions, procedures (excluding surgical procedures), or outcomes associated with these conditions.

Endocrine measures. Endocrine conditions most often result from the

endocrine system producing either too much or too little of a particular hormone. In the United States, two of the most common endocrine disorders are diabetes and osteoporosis. Diabetes, a group of diseases characterized by high blood glucose levels, affects as many as 25.8 million Americans and ranks as the seventh leading cause of death in the United States. Osteoporosis, a bone disease characterized by low bone mass and density, affects an estimated 9 percent of U.S. adults age 50 and over. Many of the diabetes measures in the portfolio are among NQF's longest-standing measures.

NQF selected the Endocrine measure evaluation project to pilot test a process improvement to allow frequent submission and evaluation of measures in order to help speed up the time from measure development to use in the field. This 22-month project will include three full endorsement cycles, allowing for the submission and review of both new and previously-endorsed measures every six months, instead of every three years which had been the norm. In addition, this project is one of the first to transition to the use of Standing Committees, meaning that the measure endorsement committee is able to review measures on a frequent basis instead of once at the start of a project as done previously.

In cycle 1, the Standing Committee recommended 14 out of 15 measures submitted for endorsement; the measures were ratified by the Board in 2014. In cycle 2, all six measures (all maintenance, no new measures were submitted) were recommended for endorsement. The measures were all process measures and related to diabetes and osteoporosis. All recommended measures were ratified in December 2014. The submission deadline for cycle 3 closed in December 2014; one composite measure and one outcome measure related to diabetes were submitted for maintenance review. The measures will be reviewed by the Committee in January 2015.

Care coordination measures. Care coordination is increasingly recognized as fundamental to the effectiveness of healthcare systems in improving patient outcomes. Poorly coordinated care regularly leads to unnecessary suffering for patients, as well as avoidable readmissions and emergency department visits, increased medical errors, and higher costs.

People with chronic conditions and multiple co-morbidities—and their families and caregivers—often find it difficult to navigate our already complex healthcare system. As this

ever-growing population transitions from one care setting to another, they are more likely to suffer the adverse effects of poorly coordinated care. Incomplete or inaccurate transfer of information, poor communication, and a lack of follow-up can lead to poor outcomes, such as medication errors. Effective communication within and across the continuum of care will improve both quality and affordability.

In the third phase of the Care Coordination project, the Standing Committee evaluated 1 new measure and 11 measures undergoing maintenance review. Eleven of the measures were recommended for endorsement by the Committee, and one was not recommended. Following review of the measures, the Committee recommended that a suite of seven measures regarding Emergency Transfer Communication be combined into one measure. The Board of Directors ratified the recommendations of the Committee in September 2014 and approved five measures (two process measures and three outcome measures) for endorsement.

All-cause admissions and readmissions measures. Unnecessary admissions and avoidable readmissions to acute care facilities are an important focus for quality improvement by the healthcare system. Previous studies have shown that nearly 1 in 5 Medicare patients is readmitted to the hospital within 30 days of discharge, costing upwards of \$426 billion annually.

In 2014, the All-Cause Admissions and Readmissions Standing Committee evaluated 15 new measures and 3 measures undergoing maintenance review against NQF's standard evaluation criteria. Fifteen of the 18 measures were recommended for endorsement by the Committee. Seventeen of the 18 measures were recommended for endorsement and approved by the CSAC. All 17 measures were ratified for endorsement by the NQF Board but only with the following conditions: A one-year look-back assessment of unintended consequences and consideration for the SES trial period.

Health and well-being measures. Social, environmental, and behavioral factors can have significant negative impact on health outcomes and economic stability; yet only 3 percent of national health expenditures are spent on prevention, while 97 percent is spent on healthcare services. Population health includes a focus on health and well-being, along with disease and illness prevention and health promotion. Using the right measures can determine how successful initiatives are

in reducing mortality and excess morbidity through prevention and wellness and help focus future work to improve population health in appropriate areas.

In phase 1, the Health and Well-Being Standing Committee evaluated seven newly submitted measures and eight measures undergoing endorsement review. One measure was withdrawn from consideration at the request of the Committee and the developer and will be evaluated in Health and Well-Being phase 2. Most new measures were related to dental care and a breast cancer screening measure was updated to reflect current guidelines. The Standing Committee recommended 13 measures for endorsement while one measure was not recommended. The 13 measures (7 process measures and 6 outcome measures) were ratified for endorsement in October 2014 and the final technical report was posted to the NQF Health and Well-Being phase 1 project Web page and submitted to HHS in December 2014.

Phase 2 of the Health and Well-Being project launched in October 2014. The call for measures is open until January 16, 2015. In this phase, seven measures are undergoing maintenance review against NQF's measure evaluation criteria.

Patient safety measures. NQF has a 10-year history of focusing on patient safety. Through various projects, NQF has previously endorsed over 100 consensus standards related to patient safety. The Safe Practices, Serious Reportable Events (SREs), and NQF-endorsed patient safety measures are important tools for tracking and improving patient safety performance in American healthcare. However, gaps still remain in the measurement of patient safety. There is also a recognized need to expand available patient safety measures beyond the hospital setting and harmonize safety measures across sites and settings of care. In order to develop a more robust set of safety measures, NQF will be soliciting patient safety measures to address environment-specific issues with the highest potential leverage for improvement.

In phase 1, the Patient Safety Standing Committee evaluated 4 new measures and 12 measures undergoing maintenance review. Eight of the measures (five process measures and three outcome measures) were recommended for endorsement by the Committee, and eight were not recommended. In addition, the Patient Safety Standing Committee conducted an ad hoc review of measure 0500, *Severe Sepsis and Septic Shock: Management Bundle*, due to change in

the underlying evidence per a randomized control trial. The Committee recommended continued endorsement of this measure.

NQF opened the phase 2 call for measures for Patient Safety measures in 2014. The Steering Committee's evaluation will take place in 2015.

Musculoskeletal measures. This project focuses on both individual and composite measures inclusive of all aspects of musculoskeletal health for all populations, with an emphasis on disparate and vulnerable populations. Improvement efforts for musculoskeletal conditions include imaging for low back pain; screening, assessment, and therapies for rheumatoid arthritis; assessment, monitoring, and therapies in the treatment of gout; and timely pain management for long bone fracture which are consistent with the NQS triple aim and align with several of the NQS priorities. NQF selected the Musculoskeletal project as the first to pilot test the optional path of eMeasure trial approval, which is intended for eMeasures that are ready for implementation but cannot yet be adequately tested to meet NQF endorsement criteria. These measures are not recommended at this stage for use in accountability applications such as public reporting or payment, but they have been judged to be ready for implementation in real-world settings in order to generate the data required to assess reliability and validity. They may be considered for endorsement after sufficient data to assess reliability and validity testing have been submitted to NQF, within three years of trial approval.

In 2014, the Musculoskeletal Standing Committee evaluated eight new measures and four measures undergoing maintenance review. Three measures were recommended for endorsement, and four measures were recommended for eMeasure trial approval. All recommended measures were process measures and related to gout and rheumatoid arthritis.

Person- and family-centered care measures. Ensuring person- and family-centered care is a core concept embedded in the National Quality Strategy priority of ensuring that each person and family is engaged as partners in their care. Person- and family-centered care encompasses the outcomes of interest to patients receiving healthcare services, including health-related quality of life, functional status, symptoms and symptom burden, and experience with care as well as patient and family engagement in care, including shared decisionmaking and preparation and activation for self-care

management. This project is focusing on patient-reported outcomes (PROs), but also may include some clinician-assessed functional status measures. NQF's 2012 project on PROs¹⁵ in performance measurement provides a basis for reviewing PRO-based performance measures, referred to as PRO-PMs.

NQF has identified 40 endorsed measures that are due for endorsement maintenance. Given the number and complexity of endorsed measures to review as well as an expectation of additional new measure submissions, NQF will undertake this project in two phases. Phase 1 examined experience with care measures, and phase 2 will review measures of functional status (clinician and patient-assessed).

In phase 1, the Standing Committee evaluated one new measure and 11 measures undergoing maintenance review. The Committee recommended 10 measures for endorsement; one measure was not recommended and one measure was withdrawn by the developer. The 10 recommended measures (all outcome measures) were ratified for endorsement in December 2014.

The second phase began in September 2014, and a total of 28 measures (14 new measures and 14 measures undergoing maintenance review) will be reviewed and evaluated. The majority of phase 2 measures are outcome measures with the exception of four process measures.

Surgery measures. The rate of surgical procedures is increasing annually. In 2010, 51.4 million inpatient surgeries were performed in the United States; 53.3 million procedures were performed in ambulatory surgery centers. Ambulatory surgery centers have been the fastest growing provider type participating in Medicare. As part of NQF's ongoing work with performance measurement for patients undergoing surgery, this project seeks to identify and endorse performance measures that address a number of surgical areas, including cardiac, thoracic, vascular, orthopedic, neurosurgery, urologic, and general surgery. This project will seek new performance measures in addition to conducting maintenance reviews of surgical measures endorsed prior to 2012 using the most recent NQF measure evaluation criteria.

In 2014, the Surgery Standing Committee evaluated 9 new measures and 20 measures undergoing maintenance review in phase 1. Twenty-one of these measures (10 outcome measures, 6 outcome measures, 2 composite measures, and 3 structural measures) were recommended (9 recommended for reserve status) for

endorsement by the Committee, 7 were not recommended, and 1 was withdrawn by the developer.

Phase 2 of this project builds on the work of the previous Surgery Endorsement project, launched in 2013. Phase 2 will seek to identify and endorse new measures that can be used to assess surgical conditions at any level of analysis or setting of care, and review endorsed measures scheduled for maintenance. The call for measures under phase 2 was initiated in 2014 and closed on January 14, 2015. A total of 26 measures will undergo maintenance review in this phase.

Eye care and ear, nose, and throat conditions measures. This project seeks to identify and endorse performance measures for accountability that address eye care and ear, nose, and throat health. Nineteen measures will undergo maintenance review using NQF's measure evaluation criteria in the areas of glaucoma, macular degeneration, hearing screening and evaluation, and ear infections. NQF initiated the call for measures in 2014.

Renal disease is a leading cause of morbidity and mortality in the United States. This project will identify and endorse performance measures for accountability and quality improvement for renal conditions. Specifically, the work will examine measures that address conditions, treatments, interventions, or procedures relating to end-stage renal disease (ESRD), chronic kidney disease (CKD) and other renal conditions. Measures that address outcomes, treatments, diagnostic studies, interventions, and procedures associated with these conditions will be considered. In addition, 21 measures will undergo maintenance review using NQF's measure evaluation criteria. NQF opened a call for measures in 2014; it will remain open until February 27, 2015.

Advancing Measurement Science

In 2014, NQF was again asked to provide guidance on emerging areas of importance by bringing together experts and diverse stakeholders to achieve consensus on next steps in deciding whether or not it is appropriate to risk adjust measures for socioeconomic and sociodemographic factors and how to best define and construct episode groupers. The reports—*Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*¹⁶ and *Evaluating Episode Groupers: A Report from the National Quality Forum*,¹⁷ were completed to help advance the science of performance measurement.

Risk Adjustment for Socioeconomic Status or other Sociodemographic Factors. With funding from HHS, NQF convened an Expert Panel tasked with considering whether to adjust performance measures for socioeconomic status (SES) and other demographic factors, including income, education, primary language, health literacy, race, and other factors. The Panel's report, released in August, has several major implications for NQF policy and the field of measurement.

Whether to adjust measures for SES and sociodemographic factors is of high interest to stakeholders who have passionate views and concerns on all sides of the issue. As a testament to these concerns, NQF received more public comments on this topic than any other project to date. All stakeholders expressed a need for performance measures to provide fair comparisons across those being measured, and also agreed that disparities in healthcare and health faced by disadvantaged patients should not be hidden. In addition there are major challenges for the providers and health plans that care for these disadvantaged populations that should not be ignored.

The Expert Panel recommended that measures should be adjusted for socioeconomic status if certain conditions are met. The panel further recommended that if a measure is adjusted for SES factors, the performance data must be stratified so that any disparities are made visible. The panel also made specific recommendations for operationalizing potential SES and sociodemographic adjustment, including guidelines for selecting risk factors and the kind of information to submit for measure review. Finally, the Panel recommended that NQF appoint a standing Disparities Committee which will ensure consistency in applying standards for SES adjusted measures and study whether or not there were unintended consequences when using such measures in the field.

Moving forward, NQF has accepted the recommendations of the Panel and will begin a two-year trial period in 2015 during which the previous NQF restriction against SES risk adjustment will be lifted.

Committees evaluating measures will be able to recommend that a measure be risk adjusted for socioeconomic or sociodemographic factors only if certain conditions are met. After the trial period concludes, NQF will determine if its criteria should be permanently changed to include SES adjustment under certain circumstances. In addition, work has begun to seat the new standing

Disparities Committee. Additional details describing the trial period will be posted on the *NQF Web site* as they become available.

Episode Grouper Criteria. Episode-based performance measurement is one approach to better understanding the utilization and costs associated with certain conditions by grouping care into condition-specific or procedure-specific episodes. Episode grouper software tools are an accepted method for aggregating claims data into episodes to assess condition-specific utilization and costs. Using an episode grouper, healthcare services provided over a defined period of time can be analyzed and grouped by specific clinical conditions to generate an overall picture of the services used to manage that condition.

Section 3003 of the Patient Protection and Affordable Care Act (Affordable Care Act) Pub. L. 111–148, requires the Secretary of HHS to develop an episode grouper. With funding from HHS, NQF convened an Expert Panel to define the characteristics and challenges of constructing episode groupers; determine an initial set of criteria by which episode groupers could be evaluated; and identify implications and considerations for NQF endorsement of episode groupers. The panel did not focus on a particular grouper or product, but instead recommended criteria that can be applied to any episode grouper that may be submitted for evaluation.

The panel recommended the following submission items for evaluation: descriptive information on the intent and planned use of the grouper; the clinical logic and data required for grouping claims; and reliability and validity testing. In particular, the panel emphasized the importance of understanding the intent and planned use for evaluating potential threats to validity and possible unintended consequences of using the grouper.

Further input from NQF's Consensus Standards Approval Committee (CSAC) confirmed the complexity of issues regarding the evaluation of episode groupers. CSAC suggested that endorsement for episode groupers is premature, however, and acknowledged there is a need for: (1) A qualitative peer review process to initially evaluate episode groupers, and (2) a process to facilitate transparency for stakeholders about what is contained within episode groups. The framework outlined in the NQF report¹⁸ addresses these needs and moves the field forward to eventual evaluation and endorsement of episode groupers.

The Panel also generally agreed that evaluation of the CMS public episode grouper would be a suitable starting point to learn and understand the feasibility of applying the approaches and criteria outlined in this report. In order to fully implement this process, additional work would be needed to refine the criteria and submission elements and build out a process for evaluation. Taking into account NQF's expertise, further efforts to explore groupers should focus on how the measures developed from an episode grouper can be evaluated and endorsed.

New Work Ahead

Since September 2014, HHS has awarded to NQF several additional endorsement projects as well as new conceptual work related to the use of HIT to further performance measurement, and work to develop measurement frameworks for both rural areas and home- and community-based services. The new endorsement work focuses on eye, ear, nose, and throat conditions, and renal care. NQF has begun these projects, as well as issuing calls for measures to be reviewed by expert panels and considered for endorsement.

Work Related to Facilitating eMeasurement

Implementation and adoption of health information technology (HIT) is widely viewed as essential to the transformation of healthcare. While the use of HIT presents many new opportunities to improve patient care and safety, it can also create new hazards, and will fulfill its potential only if the risks associated with its use are identified and a coordinated effort is developed to mitigate those risks.

An HIT-related safety event—sometimes called “e-iatrogenesis”—has been defined as “patient harm caused at least in part by the application of health information technology.”¹⁹ Detecting and preventing HIT-related safety events is challenging, because these are often multifaceted events, involving not only potentially unsafe technological features of electronic health records, for example, but also user behaviors, organizational characteristics, and rules and regulations that guide most technology-focused activities.

This project will be guided by a multistakeholder NQF Committee which includes experts in health information technology data systems and electronic health records, providers across different settings, front-line clinicians, public and private payers, and experts in patient safety issues related to the use of HIT. The

Committee will work to explore the intersection of HIT and patient safety in order to create a report that will provide a comprehensive framework for assessment of HIT safety measurement efforts, a measure gap analysis and recommendations for gap-filling, and best practices and challenges in measurement of HIT safety issues to-date. In 2014, NQF released a call for nominations and finalized the standing committee for this project.

In addition, NQF was awarded a project on value sets in late 2014 that will begin in 2015.

IV. Stakeholder Recommendations on Quality and Efficiency Measures and National Priorities

Measure Applications Partnership

Under section 1890A of the Act, HHS is required to establish a pre-rulemaking process under which a consensus-based entity (currently NQF) would convene multistakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures for use in certain federal programs. The list of quality and efficiency measures HHS is considering for selection is to be publicly published no later than December 1 of each year. No later than February 1 of each year, the consensus-based entity is to report the input of the multistakeholder groups, which will be considered by HHS in the selection of quality and efficiency measures.

The Measure Applications Partnership (MAP) is a public-private partnership convened by NQF, as mandated by the ACA (Pub. L. 111-148, section 3014). MAP was created to provide input to HHS on the selection of performance measures for more than 20 federal public reporting and performance-based payment programs. Launched in the spring of 2011, MAP is composed of representatives from more than 90 major private-sector stakeholder organizations, 7 federal agencies, and approximately 150 individual technical experts. For detailed information regarding the MAP representatives, criteria for selection to MAP and length of service, please see Appendix D.

MAP provides a forum to get the private and public sectors on the same page with respect to use of measures to enhance healthcare value. In addition, MAP serves as an interactive and inclusive vehicle by which the federal government can solicit critical feedback from stakeholders regarding measures used in federal public reporting and payment programs. This approach augments CMS' traditional rulemaking, allowing the opportunity for substantive input to HHS in advance of rules being

issued. Additionally, MAP provides a unique opportunity for public- and private-sector leaders to develop and then broadly review and comment on a future-focused performance measurement strategy, as well as provide shorter-term recommendations for that strategy on an annual basis. MAP strives to offer recommendations that apply to and are coordinated across settings of care; federal, state, and private programs; levels of attribution and measurement analysis; payer type; and points in time.

In 2014, the MAP took on several diverse tasks focused on recommending measures for federal public reporting and payment programs; developing "families of measures" (groups of measures selected to work together across settings of care in pursuit of specific healthcare improvement goals); and providing input on measures for vulnerable populations, including Medicare-Medicaid enrollees and adults and children enrolled in Medicaid.

2014 Pre-Rulemaking Input

On December 1, 2013, MAP received and began reviewing a list of 234 measures under consideration by HHS for use in more than 20 Medicare programs covering clinician, hospital, and post-acute care/long-term care settings. *The MAP Pre-Rulemaking Report: 2014 Recommendations on Measures Under Consideration by HHS*²⁰ represents the MAP's third annual round of input regarding performance measures under consideration for use in federal programs.

In this pre-rulemaking report issued in 2014, MAP recommended that HHS include 216 measures in different Medicare programs. As MAP supported some measures for use in multiple programs, this equaled 115 unique measures. Further, MAP recommended that HHS remove 48 measures from the programs. To sharpen its feedback, MAP provided new descriptions for its recommendations. Starting this year, it initiated the term "conditional support" in order to define explicit conditions that must be resolved before a measure receives MAP's full support for implementation. This designation, which replaces the previous option of "supporting the direction" of a measure, provides a clearer pathway for getting the measure into use.

MAP enhanced its 2014 pre-rulemaking process by utilizing the following approach (also contained in Appendix C of the pre-rulemaking report):

- MAP's deliberations were informed by its prior work, including its 2012 and

2013 pre-rulemaking reports, families of measures, and measure gaps previously identified across all MAP reports.

- MAP used its Measure Selection Criteria to evaluate existing measures in use by programs before receiving the new measures under consideration to help make meetings more efficient.

- Building upon its program measure set evaluations, MAP determined whether the measures on HHS' list of measures under consideration would enhance the program measure sets and provided rationales for its recommendations.

- Finally, after reviewing the measures under consideration, MAP reassessed the program measure sets for remaining high-priority gaps.

In its 2014 pre-rulemaking report, MAP noted some progress towards both measurement alignment—uniform use of measures across federal programs—and filling of measure gaps. In terms of measure alignment, MAP found that a majority of measures are being used in more than one HHS program. While this is promising, MAP noted the need to make further progress in using similar measures across a variety of public- and private-sector initiatives. In terms of measure gaps, MAP found similarly mixed results. Although there are now measures deployed to address areas in which there had previously been no meaningful way to measure performance, multiple gaps remain. These gaps include critical hospital safety measure gaps in the Inpatient Hospital Quality Reporting, Hospital Value-Based Purchasing, and Hospital Acquired Conditions Reduction Programs and clinician outcome measures for the Value-Based Payment Modifier and Physician Compare. MAP members have noted that they would like to see a more systematic assessment of ongoing progress towards gap-filling going forward.

2015 Pre-Rulemaking Input

In 2014, the MAP also began work on the 2015 Pre-Rulemaking Report. The four MAP workgroups—Clinician, Dual Eligible Beneficiaries, Hospital, and Post-Acute Care/Long-Term Care—met individually in December to review and provide input to the MAP Coordinating Committee on measure sets for use in federal programs addressing their respective populations. A report detailing recommended measures will be released on February 1, 2015. In addition, two topical pre-rulemaking reports will be issued in 2015, one on hospital and PAC/LTC programs (February 15, 2015) and another on clinician programs and cross-cutting measures (March 15, 2015).

Families of Measures: Affordability, Person- and Family-Centered Care, and Population Health

In 2014, HHS again tasked the MAP to identify new families of measures—groups of measures selected to work together across settings of care in pursuit of specific healthcare improvement goals—in three high-priority areas that relate to NQS priorities: Affordability, person- and family-centered care, and population health. In July 2014, the MAP Task Forces for the Affordability, Person- and Family-Centered Care, and Population Health topics released a final report, *Finding Common Ground for Healthcare Priorities: Families of Measures for Assessing Affordability, Population Health, and Person- and Family-Centered Care*.²¹

There were several cross-cutting issues that emerged across these three families of measures. First, measures need to be aligned with important concept areas, such as the aims of the NQS. Second, families of measures provide a tool that stakeholders can use to identify the most relevant available measures for particular measurement needs, promoting alignment by highlighting important measurement categories that can be applied to other measurement initiatives. And finally, while families include important current measures, there are not sufficient measures for assessing several priority areas within each family. This finding highlights the need for further development of measures in affordability, population health, and person- and family-centered care.

Affordability Family of Measures

Measurement plays a critical role in improving affordability. Rising healthcare costs are affecting all stakeholders, and all stakeholders have a shared responsibility for making care affordable. In order to help address this issue, MAP and NQF staff went through a multistage process to identify the most promising affordability measures to constitute a family of related measures. These measures were identified and selected based on evidence of impact, such as the leading causes of preventable death or the conditions associated with highest healthcare spending. Measures were then separated into two overarching categories, measures of current spending, and measures of cost drivers. A chart detailing the framework and measures identified for the Affordability Family are included in Appendix C of the report,²² *Finding Common Ground for Healthcare Priorities: Families of*

Measures for Assessing Affordability, Population Health, and Person- and Family-Centered Care.

On a broader level, MAP pointed out that the current United States health system is opaque in terms of price and cost. This lack of transparency is a challenge for patients who cannot find out in advance what any given healthcare service will cost. In addition, to fully understand efficiency and value, cost measures must be considered in conjunction with measures of quality. This would allow consumers to understand trade-offs between cost and quality and would allow the user to identify when cost can be reduced while maintaining or improving quality.

MAP also noted that current measures are limited in their ability to describe the full cost picture. In addition, MAP highlighted that there are direct and indirect costs from disease and treatment, and that current measures focus on direct costs while excluding indirect costs that may be significant for patients and families, e.g., transportation to providers, lost income from missing work. An additional challenge is the limited number of composite measures that provide high-level information to consumers, payers, and purchasers and give them a big picture idea of affordability. Further work is needed to produce measures that comprehensively capture cost at multiple levels.

Population Health Family of Measures

Measuring the upstream determinants of health, both in healthcare and community settings, is critical for improving population health. Although it is important to focus on the health of the entire population, attention should also be given to health disparities and the unique needs of subpopulations. Focusing on interventions that both improve the health of people in geographic or geopolitical areas as well as population-based outcomes will help achieve the goals of the NQS. For the Population Health Family of Measures, MAP selected measures of clinical preventive services, such as screenings and immunizations, as well as a number of measures that address topics outside of the traditional healthcare system. In addition, MAP considered how measures could be used in applications such as a community health needs assessment and public health activities. This approach coincides with efforts to redirect focus from individual sick care to the health and well-being of populations.

MAP selected a family of population health measures based on an overarching framework and broad

measurement domains which included consideration for measures of total population health, determinants of health, and health improvement activities. MAP refined this conceptual framework to identify topic areas that address key aspects of population health, with the final groupings largely aligning with the Healthy People 2020 Leading Health Indicator topic areas. A chart detailing the framework and measures identified for the Affordability Family are included in Appendix D of the report,²³ *Finding Common Ground for Healthcare Priorities: Assessing Affordability, Population Health, and Person- and Family-Centered Care*.

Person- and Family-Centered Care Family of Measures

Collaborative partnerships between persons, families, and their care providers are critical to enabling person- and family-centered care across the healthcare continuum. Family involvement has been correlated with improved patient and family outcomes and decreased healthcare costs. Given the positive impact that person- and family-centered care can have, measurement should strive to not only capture patients' experience of care but also include patient-reported measures that evaluate meaningful outcomes for those receiving care.

Working with a set of guiding principles for person- and family-centered care, MAP focused on creating a family of measures that covered five high priority topic areas: interpersonal relationships, patient and family engagement, care planning and delivery, access to support, and quality of life. A chart detailing the high-priority topic areas and measures identified for the Person- and Family-Centered Care Family of measures is included in Appendix E of the report,²⁴ *Finding Common Ground for Healthcare Priorities: Assessing Affordability, Population Health, and Person- and Family-Centered Care*. Also included under Appendix E is a crosswalk of all the pertinent CAHPS survey tools at the measure level to the topic areas within the family of measures.

2014 Input on Quality Measures for Dual Eligible Beneficiaries

In support of the NQS aims to provide better, more patient-centered care as well as improve the health of the U.S. population through behavioral and social interventions, HHS asked NQF to again convene a multistakeholder group via MAP to address measurement issues related to people enrolled in both the Medicare and Medicaid programs—a population often referred to as the “dual

eligibles” or Medicare-Medicaid enrollees. In August 2014, MAP released its fifth report focused on this population: *2014 Input on Quality Measures for Dual Eligible Beneficiaries*.²⁵

In this report, MAP provided its latest guidance to HHS on the use of performance measures to evaluate and improve care provided to Medicare-Medicaid enrollees. Building on prior work in this area, MAP:

- Updated the Family of Measures for Dual Eligible Beneficiaries and described persistent gaps in measures;
- Explored strategies to improve health-related quality of life by fostering shared accountability across providers on a given team; and
- Described an approach to gathering feedback from stakeholders across the field using measures focused on Medicare-Medicaid enrollees to inform MAP’s future decisionmaking.

The Family of Measures for Dual Eligible Beneficiaries is a group of 59 total measures determined to be the best available to address the needs of this unique population. It was updated in 2014 with the removal of two measures and the addition of one measure. The measures MAP removed related to e-prescribing and HIV screening, and were no longer NQF-endorsed or being maintained by their measure stewards. Three newly endorsed measures were considered for inclusion into the Family and one measure (NQF #2158 Payment-Standardized Medicare Spending Per Beneficiary) was added to address the important topic of cost. The Family still lacks an equivalent measure of costs incurred by Medicaid in caring for Medicare-Medicaid enrollees.

MAP also continued to monitor the pipeline of measures in development that are relevant to Medicare-Medicaid enrollees, including six measures NCQA is designing for use in managed long-term services and supports programs. Critical measure gap areas remain, including shared decisionmaking and psychosocial needs.

Since the start of MAP’s work, quality of life has been identified as a high-leverage opportunity for improvement through measurement. MAP discussed methods for measuring and improving quality of life outcomes tied to long-lasting health conditions. Specifically, MAP’s report describes how the medical model needs to be coupled with a social orientation to providing care and supports. Four tactics are explored: person- and family-centered care, team-based approaches to care, shared accountability, and shared decisionmaking. MAP looked to current examples of how quality of life has been

quantified, including indicators and surveys such as the CMS CARE Tool that measures functional status, and the National Core Indicators survey that evaluates quality of life aspects as reported by consumers with developmental disabilities.

2014 Report on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

MAP reviewed the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) to carefully evaluate and identify opportunities to improve the measures in use. In doing so, MAP considered states’ feedback from the first year of implementation and applied its standard Measure Selection Criteria. MAP supported the continued use of most measures in the Core Set to maintain stability for participating states. The committee recommended the removal of one measure (NQF #0063 Comprehensive Diabetes Care: LDL-C Screening) because clinical guidelines underpinning it are in flux. Additionally, MAP requested the phased addition of up to three measures to the Core Set, addressing the topics of diabetes care, medication management for asthma, and care transitions.

MAP recommended that HHS continue to support states’ efforts to gather, report, and analyze data that inform quality improvement activities. The Medicaid core set program is still new, and uses of quality data are expected to gradually mature from an internal focus on accuracy and year-over-year improvement to a more sophisticated approach involving benchmarking and public reporting. At the same time, HHS and MAP remain conscious that states are voluntarily participating in submitting data on the Medicaid Adult Core Set and need to be mindful of that reality. The program measure set will continue to evolve in response to changing federal, state, and stakeholder needs and its maintenance should be considered a long-term strategic goal.

Strengthening the Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP, 2014

HHS awarded NQF additional work in 2014 to assess and strengthen the Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP (Child Core Set). Using a similar approach to its review of the Adult Core Set, MAP performed an expedited review over a period of ten weeks to provide input to HHS within the 2014 federal fiscal year. MAP considered states’ feedback from their ongoing

participation in the voluntary reporting program and applied its standard measure selection criteria to identify opportunities to improve the Child Core Set.

MAP supported the continued use of all but one measure in the Child Core Set—Percentage of Eligibles That Received Dental Treatment Services—because it is not actionable for quality improvement purposes. Additionally, MAP requested the phased addition of up to six measures to the Child Core Set, two of which are oral health measures that would serve as appropriate replacements for the measure suggested for removal. Other measures MAP recommended for addition address family experience of hospital care, suicide risk assessment for children and adolescents with major depression, and birth outcomes.

MAP members discussed numerous cross-cutting and strategic issues related to this reporting program, including limitations in the data infrastructure to support measurement, feasibility concerns for measures not specified for state-level analysis, and increasing alignment of Child Core Set measures with the Medicaid Adult Core Set and other quality reporting programs. A major strategic consideration for the future direction of the Child Core Set is the large volume of pediatric measures in development under the auspices of the AHRQ—CMS Pediatric Quality Measures Program (PQMP); these measures will become available for MAP’s consideration over the course of the next year.

V. Gaps in Endorsed Quality and Efficiency Measures and Evidence and Targeted Research Needs

Under section 1890(b)(5)(iv) of the Act, the entity is required to describe gaps in endorsed quality and efficiency measures, including measures within priority areas identified by HHS under the agency’s National Quality Strategy, and where quality and efficiency measures are unavailable or inadequate to identify or address such gaps. Under section 1890(b)(5)(v) of the Act, the entity is also required to describe areas in which evidence is insufficient to support endorsement of quality and efficiency measures in priority areas identified by the Secretary under the National Quality Strategy and where targeted research may address such gaps.

MAP Pre-Rulemaking Input Related to Gap Filling

NQF continued in 2014 to address the need to fill measurement gaps to build on and supplement the analytic work

that has informed previous Measure Gap Analysis Reports as well as other MAP reports. However, much work remains to be done by measure developers, NQF, and many other entities to accelerate the closing of gaps.

With each MAP pre-rulemaking cycle, MAP examines progress on both alignment and measure gap-filling, and assesses how best to achieve these objectives. MAP's 2014 pre-rulemaking review of proposed measures submitted by HHS yielded a list of topic areas that needed measures that was largely the same as the one developed the previous year. Public commenters generally agreed with the gap areas identified on the NQF list, which include gaps in:

- Safety: Healthcare-associated infections, medication and infusion safety, perioperative/procedural safety, pain management, venous thromboembolism, falls and mobility, and obstetric adverse events;
- Patient and family engagement: Person-centered communication, shared decisionmaking and care planning, advanced illness care, and patient-reported measures;
- Healthy living: Well-being, healthy lifestyle behaviors, social and environmental determinants of health, social connectedness for people with long-term services and supports needs, sense of control/autonomy/self-determination, and safety risk assessment;
- Care coordination: Communication, care transitions, system and infrastructure support, and avoidable admissions and readmissions;
- Affordability: Ability to obtain follow-up care, total cost of care, consideration of patient out of pocket cost, and use of radiographic imaging in the pediatric population;
- Prevention and treatment of leading causes of mortality: Primary and secondary prevention, cancer, cardiovascular conditions, depression, diabetes, and musculoskeletal conditions.

MAP has observed mixed results in filling measure gaps. An example of a success story is the CAHPS In-Center Hemodialysis Survey measure (NQF #0258) for the ESRD Quality Incentive Program that MAP supported in its 2014 review because it fills a previously identified measure gap in consumers' experience of care. HHS now plans to implement this measure.

NQF is working with measure developers and other stakeholders to more rapidly expand the pipeline of new measures that may ultimately become endorsed. Such efforts include more frequent measure submission and endorsement review opportunities,

consideration of new approaches to endorsement dependent on application, implementation of trial use endorsement designation for e-measures, and exploring the development of a measure incubator.

In the meantime, the drive to expeditiously fill measure gaps played a role in MAP's decision to support a limited number of measures—less than 20—that are currently not NQF-endorsed with expectations that they would be later reviewed for endorsement by NQF. MAP also noted critical measure gap areas during the creation of measure families. If maintained and applied broadly, measure families can help achieve increased alignment and keep attention focused on high-priority measure gaps. Public commenters expressed strong support for the use and continued development of MAP measure families.

Priority Setting for Health Care Performance Measurement: Addressing Performance Gaps in Priority Areas

In an effort to get more specific and detailed guidance to developers with respect to key measurement gap areas, HHS requested in 2013 that NQF recommend priorities for performance measurement development across five topics areas specified by HHS, including:

- Adult immunization—identifying critical areas for performance measurement to optimize vaccination rates and outcomes across adult populations;
- Alzheimer's disease and related dementias—targeting a high-impact condition with complex medical and social implications that impact patients, their families, and their caregivers;
- Care coordination—focusing on team-based care and coordination between providers of primary care and community-based services in the context of the “health neighborhood”;
- Health workforce—emphasizing the role of the workforce in prevention and care coordination, linkages between healthcare and community-based services, and workforce deployment; and

- Person-centered care and outcomes—considering measures that are most important to patients—particularly patient-reported outcomes—and how to advance them through health information technology.

In 2014, NQF has completed these analyses through the use of topic-specific committees that were tasked with reviewing the evidence base and existing measures to identify opportunities for using performance measurement to improve health and

healthcare, as well as to reduce disparities, costs, and measurement burden. After these environmental scans, the committees then developed measurement frameworks for each topic which helped identify measure gap areas. In 2014, NQF submitted five final reports to HHS (Adult Immunization, Care Coordination, Health Workforce, Person-Centered Care and Outcomes, and Alzheimer's Disease and Related Dementias). These five reports are described in more detail below.

Adult Immunization

The Adult Immunization Committee—with the help of an advisory group—submitted a report titled, *Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps for Adult Immunizations*,²⁶ in August 2014 that builds on concepts identified by the Quality and Performance Measures Workgroup of the HHS Interagency Adult Immunization Task Force, and seeks to illustrate measure gaps in specific age bands and special populations including young adults, pregnant women, the elderly, and adults overall.

A total of 225 unique measures or concepts were identified as relevant to adult immunization. An analysis of the identified measures showed that there is a plethora of measures that address influenza immunization (79 measures, 35 percent of identified measures) and pneumococcal immunization (60 measures, 27 percent of identified measures). The majority of measures identified in the environmental scan are process measures (69 percent) and only 4 of the 46 outcome measures are at the provider level; the majority are population and surveillance measures.

The Committee then developed and used a conceptual measurement framework to prioritize measurement needs and identify more than 30 potential measure gaps. The gaps were grouped into several measure categories requested by HHS: Adult vaccines for which there are no NQF-endorsed measures; vaccines for specific age groups consistent with the adult immunization schedule issued by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP/CDC); vaccines for specific populations such as persons with diabetes or other chronic conditions; vaccines for healthcare personnel; composite measures including both immunizations alone and composite measures that include other clinical preventive services; outcome measures; and

measures for Immunization Information Systems.

The Committee then discussed the results at an in-person meeting and agreed upon the 10 measure gap priorities listed below.

Age-Specific Priorities

- HPV vaccination catch-up for females ages 19–26 years and for males-ages 19–21 years
- Tdap/pertussis-containing vaccine for ages 19+ years
- Zoster vaccination for ages 60–64 years
- Zoster vaccination for ages 65+ years (with caveats)

Composite Measure Priorities

- Composite including immunization with other preventative care services as recommended by age and gender
- Composite of Tdap and influenza vaccination for all pregnant women (including adolescents)
- Composite including influenza, pneumococcal, and hepatitis B vaccination measures with diabetes care processes or outcomes for individuals with diabetes
- Composite including influenza, pneumococcal, and hepatitis B vaccinations measures with renal care measures for individuals with kidney failure/end-stage renal disease (ESRD)
- Composite including Hepatitis A and B vaccinations for individuals with chronic liver disease
- Composite of all ACIP/CDC recommended vaccinations for healthcare personnel

To provide further guidance, the Committee also identified two short-term and long-term priorities from the list of 10 measure gap priorities above:

Short-Term Priorities:

- HPV vaccination catch-up for females ages 19–26 years and for males ages 19–21 years
- Composite of Tdap and influenza vaccination for all pregnant women (including adolescents)

Long-Term Priorities:

- Composite measures that include immunization with other preventative care services
- Composite measures for healthcare personnel of all ACIP/CDC recommended vaccines

Alzheimer's Disease and Related Dementias

The Alzheimer's Disease and Related Dementias Committee was charged with developing a conceptual measurement framework and recommending priorities for future performance measurement development in this area. NQF submitted a draft conceptual framework

and environmental scan in February 2014 which was used by the committee to create their final report, *Priority Setting for Healthcare Performance Measurement: Alzheimer's*.²⁷

The project's environmental scan yielded 125 dementia-specific performance measures. To identify measure gaps, NQF staff mapped these measures to the National Quality Strategy priority areas. This analysis showed that there is a need for performance measures focused on the well-being of caregivers, person- and family-centered measures, and outcome measures focused on quality of life and experience of care, and measures of affordability.

Using the information from the environmental scan, the Committee developed a conceptual measure framework and recommended priorities for future performance measurement development. Five measurement themes emerged as the committee deliberated: Importance of connection to community-based services, need for accountability at the community level, a focus on person- and family-centered approaches, diagnostic accuracy, and safety. The committee also recommended the following three areas as the highest priority for measure development: Composite measure of comprehensive diagnostic evaluation and needs assessment, composite measure of caregiver support, and measures to reflect a dementia-capable healthcare and community care system.

Finally, the Committee identified broad recommendations for performance measurement related to dementia as well as overarching policy recommendations. These recommendations included stratifying existing performance measures to assess quality of care for those with dementia, modifying the CAHPS surveys to allow proxy response for those with dementia so that their experience of care can be recorded, and using existing data sources to aid research that could identify those who should be assessed for cognitive impairment.

Care Coordination

The multistakeholder Expert Committee guiding this work focused on examining opportunities to measure care coordination, particularly between providers of primary care and health-related services provided in the community. The conceptual framework adopted by the Committee describes a three-way set of relationships between care recipients, clinics/clinicians, and community resources. The framework notes that the most powerful measures that could be developed would capture

the interaction of all three elements. The Committee also provided additional recommendations to enhance the practice of care coordination itself.

The Care Coordination Committee framework builds on work from the Agency for Healthcare Research and Quality's *Care Coordination Measures Atlas* and their Clinical-Community Relationship Measurement concept. The project's environmental scan identified a total of 363 measures related to care coordination, most of which were general, and uncovered very few measures related to ongoing interactions between primary care and community-based service providers to support improved health and quality of life. In general, currently available measures are either too narrowly or too broadly designed to be actionable by providers of primary care. Further, no available measures directly apply to providers of community services.

The Committee recommended quick and deliberate action in their report, *Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination*,²⁸ particularly in filling performance measure gaps in four high-impact areas:

1. Linkages and synchronization of care and services to promote the purposeful collaboration of all members of a care team, achieved through continuous monitoring of individuals' care plans, multidirectional communication, and problem-solving.
2. Individuals' progression toward goals for their health and quality of life, with measurement centered on whether care recipients have a person-centered care plan and the support required to make reasonable progress toward their goals.
3. A comprehensive assessment process that incorporates the perspective of a care recipient and anyone who plays a role in addressing that person's needs; both medical and psychosocial risk factors should inform the determination of how to coordinate delivery of care and supports.
4. Shared accountability within a care team that hinges upon all team members understanding their responsibilities for contributing to progress toward the care recipient's goals.

Successful care coordination relies upon the execution of a care plan that includes a structured arrangement of standardized data elements. However, such standardization is not yet widespread and this has been a barrier to systematic measurement of care coordination activities.

Health Workforce

Achieving the National Quality Strategy's aims of better care, affordable care, and healthy people/healthy communities requires an adequate supply and distribution of a well-trained workforce. Therefore, in consultation with HHS and with input from advisory members, NQF developed a draft conceptual framework for measurement that captures elements necessary for successful and measureable workforce deployment. This framework provided the basis for the report, *Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps for the Health Workforce*.²⁹

A total of 252 measures were identified in the environmental scan as potential health workforce measures. Large sets of measures were found related to training and development, mostly related to professional educational programs and the number of graduates in specific health professions. Although many measures of patient and family experience of care related to workforce performance were identified, few measures capturing workforce experience were found. Workforce capacity and productivity measures proved to have a substantial presence, especially those related to geographical distribution and skill mix.

Eight domains within the framework were identified as key areas for measurement:

1. Training, retraining, and development
2. Infrastructure to support the health workforce and to improve access
3. Retention and recruitment
4. Assessment of community and volunteer workforce
5. Experience (health workforce and person and family experience)
6. Clinical, community, and cross disciplinary relationships
7. Workforce capacity and productivity
8. Workforce diversity

Within the eight domains above, the Committee identified the five highest priority domains for measurement in the near term, and recommended concepts for measurement.

Public comments echoed the Committee's acknowledgement of new and future initiatives in this area, which will impact and improve workforce measurement, particularly those that capture person- and family-centered perspectives, and address vulnerable populations and under-resourced geographic areas. Future measure development could focus on measures of health workforce deployment and use resulting in the greatest impact on health outcomes.

Person-Centered Care and Outcomes

HHS charged NQF with convening a multistakeholder committee to prioritize the person- and family-centered care performance measurement gaps that need to be addressed. The Committee provided its recommendations in the report, *Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Person-Centered Care and Outcomes*.³⁰

The Committee highlighted three key principles that should inform the identification of measure concepts for person- and family-centered care. The concepts are:

- Selected and/or developed in partnership with individuals to ensure measures are meaningful to those receiving care;
- focused on the person's entire care experience, rather than a single setting, program, or point in time; and
- measured from the person's perspective and experience.

The Committee identified specific measure concepts for potential measure development, and recommended priorities for measuring performance on person- and family-centered care. Overarching recommendations included integrating individual and family input into performance measure development decisions, focusing measurement on person-reported experiences, going beyond silos of accountability and measurement by challenging the norms of the current healthcare environment, and considering how those being measured would act on the information.

In the short term, the Committee had several recommendations that could be implemented almost immediately by providers and healthcare systems when caring for patients. These recommendations include focusing on patients with higher levels of need such as those with comorbidities, advanced dementia and other serious illnesses; considering the use of Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance measures; and convening CAHPS and Patient Reported Outcomes Measurement Information System (PROMIS) experts for mutual learning in applying new methods of measurement.

Identifying Other Measure Gaps

NQF identified additional high-priority measure gaps as a natural byproduct of NQF's endorsement and maintenance work. Those gaps are listed by topic area in Appendix E of this report.

In addition to identifying gaps through measure endorsement work and through the topical gaps reports, the

Dual Eligible Beneficiaries Workgroup identified the following gaps in their report, *2014 Input on Quality Measures for Dual Eligible Beneficiaries*.³¹

- Goal-directed, person-centered care planning and implementation
- Shared decisionmaking
- Systems to coordinate healthcare with nonmedical community resources and service providers
- Beneficiary sense of control/ autonomy/self-determination
- Psychosocial needs assessment and care planning
- Community integration/inclusion and participation
- Optimal functioning (e.g., improving when possible, maintaining, managing decline)

Importantly, this list reflects the MAP's vision specifically for high-quality care for Medicare-Medicaid enrollees but also applies more broadly to the general population as MAP has articulated in previous reports. Identification of these gaps supports a philosophy about health that broadly accounts for individuals' health outcomes, personal wellness, social determinants (e.g., housing, transportation, access to community resources), and desire for a more cohesive system of care delivery. Many gaps are long-standing, which underscores both the importance of nonmedical supports and services in contributing to improved healthcare quality and the difficulty of quantifying and measuring these factors as indicators of performance.

Specifically, MAP recommends for future measure development continuing a focus on topics that address the social issues that affect health outcomes in vulnerable populations, including individuals with a history of incarceration and veterans of military service. MAP will continue to communicate with measure developers and other stakeholders positioned to help fill measurement gaps.

Although MAP's work to-date on measure gaps—including the pre-rulemaking efforts and input from specific workgroups—is starting to bear fruit, persistent gaps across sectors, such as care coordination and patient experience of care, continue to frustrate measurement efforts. Current measures fail to capture the complex and dynamic array of conditions that are at play in an acutely or chronically ill person's life over time. Resources outside of MAP's control need to be allocated to research that can explore new methodologies for measurement of complex topics such as nonclinical processes and person-centered outcomes. However, MAP, in

coordination with NQF's larger initiatives, will continue to try to influence ongoing progress in filling measure gaps through its specific recommendations and by enhanced collaboration with other stakeholders.

VI. Conclusion and Looking Ahead

NQF has evolved in the 15 years it has been in existence and since it endorsed its first performance measures more than a decade ago. While its focus on improving quality, enhancing safety, and reducing costs by endorsing performance measures has remained a constant, its role has expanded through both public and private support, including from foundations and member dues.

More specifically, NQF has convened multiple private sector stakeholders to help inform the development and implementation of the first-ever National Quality Strategy and to advise CMS on selection of measures for 20 plus federal programs. Other examples of recent work beyond endorsement include an NQF-funded Kaizen, or lean,

process improvement undertaken to streamline MAP and performance measurement processes in conjunction with CMS and ONC. In 2014, NQF also worked with CMS and America's Health Insurance Plans (AHIP) to identify a common, discrete set of aligned measures that both the public and private payers agree to request from physicians and other providers.

With respect to NQF's recent work through MAP to identify measure gaps in order to catalyze the field to fill them, several important conclusions have been drawn. MAP reported in its 2014 pre-rulemaking review of proposed measures that the topic areas that need measures were largely the same as from the previous year. Those gaps are in safety, patient and family engagement, healthy living, care coordination, affordability, and prevention and treatment of leading causes of mortality. Measure development in these areas should be a priority. NQF's initial efforts to define in detail measures needed in these and other high-priority

areas may help fill these gaps. NQF is also exploring efforts to partner with other organizations to address persistent measure gaps, including potential development of a measure incubator.

In 2015, with funding from HHS, NQF is tackling several critical issues affecting healthcare quality and safety that will help advance the aims and priorities of the National Quality Strategy, as well as building on landmark work done in 2014 such as readmissions and issues regarding risk adjustment for socioeconomic and sociodemographic factors. The work in the year ahead will include NQF simultaneously culling and building out a measurement portfolio that drives the healthcare system to delivering higher value healthcare at lower cost. NQF will also serve as a forum for all stakeholders across the public and private sectors to contribute to furthering the future of measurement and quality improvement for the nation.

Appendix A: 2014 Activities Performed Under Contract With HHS

Description	Output	Status (as of 12/31/2014)	Notes/scheduled or actual completion date
1. Recommendations on the National Quality Strategy and Priorities			
Multistakeholder input on a National Priority: Improving Population Health by Working with Communities.	A common framework that offers guidance on strategies for improving population health within communities.	Phase 1 completed ...	Phase 1 completed August 2014.
Multistakeholder input into the Quality Rating System.	Review and input into core measures and organization of information for the Health Insurance Marketplaces Quality Rating System.	Phase 2 in progress. Completed	Phase 2 in progress. Completed January 2014.
Multistakeholder Action Pathway Model in support of the Partnership for Patients (PfP) Initiative.	Quarterly reports and meetings detailing progress of three action teams addressing maternity care, readmissions, and patient and family engagement.	Completed	Quarterly meetings held on: <ul style="list-style-type: none"> • January 29, 2014 • April 24, 2014 • July 14, 2014 • October 3, 2014. Quarterly reports released on: <ul style="list-style-type: none"> • January 31, 2014 • April 30, 2014 • July 31, 2014 • October 15, 2014.
Common Formats for patient safety data	A set of comments and advice for further refining additional modules for the Common Formats, an AHRQ-based initiative that helps standardize electronic reporting of patient safety event data.	In progress	Completed-comments received in 2014 reviewed by Expert Panel and given to AHRQ.
2. Quality and Efficiency Measurement Initiatives			
Behavioral health	Set of endorsed measures for behavioral health.	Phase 2 Completed .. Phase 3 in progress ..	Phase 2 endorsed 20 measures in May 2014. Phase 3 will be completed in May 2015.
Readmissions and all-cause admissions and readmissions measures and maintenance review.	Set of endorsed measures for admissions and readmissions.	In progress	Will be completed in March 2015.
Cost and resource use measures	Set of endorsed measures for cost and resource use.	Phase 2 in progress .. Phase 3 in progress ..	Phase 2 will be completed in March 2015. Phase 3 will be completed in March 2015.

Description	Output	Status (as of 12/31/2014)	Notes/scheduled or actual completion date
Cardiovascular measures and maintenance review.	Set of endorsed measures for cardiovascular conditions.	Phase 1 Completed .. Phase 2 in progress .. Phase 3 in progress ..	Phase 1 completed November 2014. Phase 2 will be completed in July 2015. Phase 3 will be completed in April 2016.
Endocrine measures and maintenance review.	Set of endorsed measures for endocrine conditions.	Phase 1 Completed .. Phase 2 in progress .. Phase 3 in progress ..	Phase 1 was completed in November 2014. Phase 2 will be completed in February 2015. Phase 3 will be completed in September 2015.
Health and well-being measures and maintenance review.	Set of endorsed measures for health and well-being.	Phase 1 Completed .. Phase 2 in progress ..	Phase 1 was completed in December 2014. Phase 2 will be completed in December 2015.
Patient safety measures and maintenance review.	Set of endorsed measures for patient safety	Phase 1 in progress .. Phase 2 in progress ..	Phase 1 will be completed in January 2015. Phase 2 will be completed in February 2016.
Care coordination measures and maintenance review.	Set of endorsed measures for care coordination.	Completed	Was completed in November 2014.
Musculoskeletal measures and maintenance review.	Set of endorsed measures for musculoskeletal conditions.	In progress	Will be completed in January 2015.
Person- and family-centered care measures and maintenance review.	Set of endorsed measures for person- and family-centered care.	Phase 1 in progress .. Phase 2 in progress ..	Phase 1 will be completed in March 2015. Phase 2 will be completed in August 2015.
Surgery measures and maintenance review	Set of endorsed measures for surgery	Phase 1 in progress .. Phase 2 in progress ..	Phase 1 will be completed in February 2015. Phase 2 will be completed in October 2015.
Eye care, ear, nose, and throat conditions measures and maintenance review.	Set of endorsed measures for eye care, ear, nose, and throat conditions.	In progress	Final report will be completed in January 2016.
Renal measures and maintenance review	Set of endorsed measures for renal care	In progress	Final report will be completed in December 2015.
Episode grouper criteria	Report examining necessary submission elements for evaluation, as well as best practices for episode grouper construction.	Completed	Final report completed September 2014.
Prioritization and identification of health IT patient safety measures.	Report will provide a comprehensive framework for assessment of HIT safety measurement efforts.	In progress	Final report will be completed in February 2016.
Quality measurement for home and community-based services.	Report will provide a conceptual framework and environmental scan to address performance measure gaps in home and community-based services to enhance the quality of community living.	In progress	Final report will be completed in September 2016.
Risk Adjustment for socioeconomic status or other sociodemographic factors.	Report providing a set of recommendations on the inclusion of socioeconomic status and other sociodemographic factors in risk adjustment for outcome and resource use performance measures.	Completed	Final report completed August 15, 2014.
Rural health	This project will provide recommendations to HHS on performance measurement issues for rural and low-volume providers.	In progress	Final report will be completed in September 2015.

3. Stakeholder Recommendations on Quality and Efficiency Measures and National Priorities

Recommendations for measures to be implemented through the 2014 federal rule-making process for public reporting and payment.	Measure Applications Partnership Pre-Rule-making Report: Input on Measures Under Consideration by HHS for 2014 Rule-making.	Completed	Completed January 31, 2014.
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Description	Output	Status (as of 12/31/2014)	Notes/scheduled or actual completion date
Recommendations for measures to be implemented through the 2015 federal rule-making process for public reporting and payment.	Measure Applications Partnership Pre-Rule-making Report: Input on Measures Under Consideration by HHS for 2015 Rule-making.	In progress	Measure specific recommendations will be completed on February 1, 2015. Hospital, PAC/LTC Programmatic Report will be completed on February 15, 2015. Clinician and Cross Cutting Report will be completed on March 15, 2015.
Synthesizing evidence and convening key stakeholders to make recommendations on families of measures and risk adjustment.	New families of measures covering affordability, population health, and person- and family-centered care. Also a final set of recommendations focused on risk adjustment for resource use performance measures.	Completed	Completed July 1, 2014.
Identification of quality measures for dual-eligible Medicare-Medicaid enrollees and adults enrolled in Medicaid.	Annual input on the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid, and additional refinements to previously published Families of Measures.	Completed	Completed August 29, 2014. Next annual recommendations due by September 1, 2015.
Identification of quality measures for children in Medicaid.	Annual input on the Initial Core Set of Health Care Quality Measures for Children enrolled in Medicaid.	In Progress	Completed November 14th, 2014. Next annual recommendations due by September 1, 2015.

4. Gaps in Evidence and Targeted Research Needs

Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps for the Health Workforce.	Recommended sets of priorities for performance improvement for the health workforce.	Completed	Completed August 15, 2014.
Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps for Adult Immunizations.	Recommended sets of priorities for performance improvement for adult immunizations.	Completed	Completed August 15, 2014.
Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination.	Recommended sets of priorities for performance improvement for care coordination.	Completed	Completed August 15, 2014.
Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Person-Centered Care and Outcomes.	Recommended sets of priorities for performance improvement for person-centered care and outcomes.	Completed	Completed August 15, 2014.
Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps for Alzheimer's Disease.	Recommended sets of priorities for performance improvement for person-centered care and outcomes.	Completed	Completed October 15, 2014.

Appendix B: Measure Evaluation Criteria

Measures are evaluated for their suitability based on standardized criteria in the following order:

1. Importance to Measure and Report: http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx#importance
2. Scientific Acceptability of Measure Properties: http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx#scientific
3. Feasibility: http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx#feasibility
4. Usability and Use: http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx#usability
5. Related and Competing Measures: http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx#comparison

More information is available on the NQF Web site at: http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx#1_2.

Appendix C: Federal Public Reporting and Performance-Based Payment Programs Considered by MAP

- End-Stage Renal Disease Quality Incentive Program
- Home Health Quality Reporting Program
- Hospice Quality Reporting Program
- Inpatient Rehabilitation Facility Quality Reporting Program
- Long-Term Care Hospital Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program
- Hospital-Acquired Condition Reduction Program
- Hospital Inpatient Quality Reporting Program
- Hospital Outpatient Quality Reporting Program
- Hospital Readmission Reduction Program
- Hospital Value-Based Purchasing Program

- Inpatient Psychiatric Facility Quality Reporting Program
- Prospective Payment System (PPS) Exempt Cancer Hospital Quality Reporting Program
- Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs
- Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs for Eligible Professionals
- Medicare Shared Savings Program
- Physician Quality Reporting System
- Physician Feedback/Value-Based Payment Modifier Program
- Physician Compare

Appendix D: MAP Structure, Members, and Criteria for Service

MAP operates through a two-tiered structure. Guided by the priorities and goals of HHS's National Quality Strategy, the MAP Coordinating Committee provides direction and direct input to HHS. MAP's workgroups advise the Coordinating Committee on measures needed for specific care settings,

care providers, and patient populations. Time-limited task forces consider more focused topics, such as developing “families of measures”—related measures that cross settings and populations—and provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes individuals with content expertise and organizations particularly affected by the work.

MAP’s members are selected based on NQF Board-adopted selection criteria, through an annual nominations process and an open public commenting period. Balance among stakeholder groups is paramount. Due to the complexity of MAP’s tasks, individual subject matter experts are included in the groups. Federal government *ex officio* members are nonvoting because federal officials cannot advise themselves. MAP members serve staggered three-year terms.

MAP members

Coordinating Committee

Committee Co-Chairs (Voting)

George J. Isham, MD, MS
Elizabeth A. McGlynn, Ph.D., MPP

Organizational Members (Voting)

AARP

Joyce Dubow, MUP
Academy of Managed Care Pharmacy
Marissa Schlaifer, RPh, MS

AdvaMed

Steven Brotman, MD, JD

AFL-CIO

Shaun O’Brien

American Board of Medical Specialties
Lois Margaret Nora, MD, JD, MBA

American College of Physicians
Amir Qaseem, MD, Ph.D., MHA

American College of Surgeons
Frank G. Opelka, MD, FACS

American Hospital Association
Rhonda Anderson, RN, DNSc, FAAN

American Medical Association
Carl A. Sirio, MD

American Medical Group Association
Sam Lin, MD, Ph.D., MBA

American Nurses Association
Marla J. Weston, Ph.D., RN

America’s Health Insurance Plans
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Blue Cross and Blue Shield Association
Trent T. Haywood, MD, JD

Catalyst for Payment Reform
Shaudi Bazzaz, MPP, MPH

Consumers Union
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Federation of American Hospitals
Chip N. Kahn, III

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Association

Richard Gundling, FHFMA, CMA
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The Joint Commission

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LeadingAge

Cheryl Phillips, MD, AGSF

Maine Health Management Coalition
Elizabeth Mitchell

National Alliance for Caregiving
Gail Hunt

National Association of Medicaid Directors

Foster Gesten, MD, FACP
National Business Group on Health
Steve Wojcik

National Committee for Quality Assurance
Margaret E. O’Kane, MHS

National Partnership for Women and
Families

Alison Shippy

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Centers for Medicare & Medicaid Services
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Kevin Larsen, MD, FACP

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Center for Health Care Reform

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American Academy of Family Physicians

Amy Mullins, MD, CPE, FAAFP

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American College of Radiology

David Seidenwurm, MD

Association of American Medical Colleges

Janis Orłowski, MD

Center for Patient Partnerships

Rachel Grob, Ph.D.

Consumers’ CHECKBOOK

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March of Dimes

Cynthia Pellegrini

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* *Representative to be determined*

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Eric Whitacre, MD, FACS; Surgical Care

Subject Matter Expert: Surgical Care

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Lisa C. Patton, Ph.D.

**Appendix E: Specific Measure Gaps
Identified Through 2014 Measure
Endorsement Work**

Cost and Resource Use

- Total cost of care
- Consumer out-of-pocket expenses
- Actual prices paid by patients and health plans
- Trends in cost performance over time at the health plan level
- Systematic cost drivers
- Costs rolled up from all levels of analysis which can be deconstructed to understand costs at lower levels of analysis

Behavioral Health

- Measures specific to child and adolescent behavioral health needs
- Outcome measures for substance abuse/dependence that can be used by substance use specialty providers
- Quality measures assessing care for persons with intellectual disabilities

- Quality measures that align indicators of clinical need and treatment selection and ideally, patient preferences
- Measures that assess aspects of recovery-oriented care for individuals with serious mental illness
- Measures related to coordination of care across sectors involved in the support of persons with chronic mental health problems
- Adapt measure concepts for inpatient care to other outpatient care settings
- Measures that assess whether evidence based psychosocial interventions are being applied consistent with their evidence base
- Expand the number of conditions for which quality of care can be assessed in the context of measurement-based care (e.g. suite of endorsed measures now available for depression)
- Measurement strategies for assessing the adequacy of screening and prevention interventions for general medical conditions
- Screening for alcohol and drugs
- Screening for post-traumatic stress disorder and bipolar disorder in patients diagnosed with depression

Cardiovascular

- Patient-reported outcome measures for heart failure symptoms and activity assessment
- Composite measures for heart failure
- Measures of cardiometabolic risk factors
- "Episode of care" composite measure for AMI that includes outcome as well as process measures
- Consideration of socioeconomic determinants of health and disparities
- Global measures of cardiovascular care

Care Coordination

- Measures focused on health information technology (IT), transitions of care, and structural measures
- Cross-cutting measures that span various types of providers and episodes of care. Such measures have the potential to be applied more broadly and be more useful for those with multiple chronic conditions
- Measures of patient-caregiver engagement
- Measures that evaluate "system-ness" rather than measures that address care within silos
- Outcome and composite measures, which are prioritized by both the Committee and MAP over individual process and structural measures, but with the recognition that some of these latter measures are valuable

Surgery

- Various specialty areas that are still in their infancy in terms of quality measurement, including orthopedic surgery, bariatric surgery, neurosurgery, and others
- Measures of adverse outcomes that are structured as "days since last event" or "days between events"; this could help address some of the concerns about measuring low-volume events
- Measures around functional status or return to function after surgery, as well as other patient-centered and patient-reported outcomes like patient experience

Health and Well-Being

- Measures that assess social, economic, and environmental determinants of health
- Measures that assess physical environment (e.g., built environments)
- Measures that assess policy (e.g., smoke-free zones)
- Measures that assess health and well-being for specific sub-populations (e.g., people with disabilities, elderly)
- Patient and population outcomes linked to improvement in functional status
- Counseling for physical activity and nutrition in younger and middle-aged adults (18 to 65 years)
- Composites that assess population experience

Endocrine

- Measures of other endocrine-related conditions, particularly thyroid disease, both for adults and for the pediatric population
- Incidence of heart attacks and strokes among persons with diabetes, measured at the health plan level
- Measures of overuse, particularly for thyroid conditions (e.g., ultrasound for thyroid nodules, overdiagnosis/ overtreatment of thyroid cancer)
- Measures for pre-diabetes/metabolic syndrome
- “Delta” measures for intermediate clinical outcomes (e.g., LDL levels, HbA1c levels)
- Education measures (e.g., for diabetes) that go beyond asking if education was provided and instead assesses whether the patient was able to understand and apply the education (needed at diagnosis, not just when complications arise)
- Measures that utilize other types of patient information (e.g., time-in-range measures for patients with continuous glucose monitors)
- More complex measures, including composite measures for diabetes screening and for neuropathy care
- Measures of hypoglycemia among the elderly, including medication safety measures
- Measures focusing on the use of testosterone
- Measures of Body Mass Index (BMI) or in adult patients with diabetes mellitus
- Patient-centered measures of lifestyle management and health-related quality of life
- Access to care and medications
- Treatment preferences, psychosocial needs, shared decisionmaking, family engagement, cultural diversity, and health literacy
- Communication, coordination, and transitions of care
- General prevention and treatment of diabetes, as well as measures of the sequelae of diabetes
- Glycemic control for complex patients (e.g., geriatric population, multiple chronic conditions) and for the pediatric population at the clinician, facility, and system levels of analysis
- Evaluation of bone density, and prevention and treatment of osteoporosis in ambulatory settings

Patient Safety

- Safety outcome measures, particularly medication safety measures
- Radiation safety measures

Musculoskeletal

- Management of chronic pain
- Use of MRI for management of chronic knee pain
- Tendinopathy: evaluation, treatment, and management
- Outcomes: spinal fusion, knee and hip replacement
- Overutilization of procedures
- Secondary fracture prevention

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III. Secretarial Comments on the 2015 Annual Report to Congress and the Secretary

The 2015 Annual Report to Congress and the Secretary by the National Quality Forum (NQF) shows the range and complexity of issues that face all people and organizations working to improve the effectiveness and efficiency of health care quality measurement. Approximately 16 percent of 600 quality measures in NQF’s portfolio of endorsed measures were removed and an almost equal percentage of new measures were added in 2014, indicating the dynamic and continuously evolving nature of the field of quality measurement. The substantial progress in strengthening the set of endorsed measures was facilitated by collaborations between NQF, the Centers for Medicare & Medicaid Services (CMS), the Office of the National Coordinator for Health Information Technology, and many other stakeholders that aimed to reduce the complexity of the measure endorsement process. The streamlined process that resulted enables more measures to be reviewed, considered for endorsement, and endorsed as appropriate.

Having a greater portfolio of endorsed measures is key to HHS’ efforts to find better ways to deliver health care, pay providers, and keep people healthy and safe. HHS uses performance measures across many programs to achieve this. For example, the INR Monitoring for Individuals on Warfarin measure (NQF # 0555) is endorsed by the CBE and adds to the existing set of measures in the Centers for Medicare and Medicaid Services (CMS)’s medication management and clinical effectiveness portfolios. This measure is especially valuable, because it addresses an important issue that can be used to improve patient safety and is useful for many CMS initiatives (e.g., CMS’s

Physician Quality Reporting System and the National Action Plan for Adverse Drug Event Prevention). The Cardiovascular Health Screening for people with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications measure (NQF # 1927) also is “cross-cutting,” applicable to measurement of such areas as care coordination and clinical effectiveness. Further, this measure can be applied to potentially reduce health disparities for individuals with mental illness and improve population health by incentivizing providers to better manage complex chronic conditions. In addition to HHS’ use of NQF-endorsed measures in current programs, having a strong slate of endorsed measures overall will help HHS in its plans to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity, of care they give patients.

However, this report also presents some weaknesses in the current portfolio of endorsed measures available to evaluate health care. With respect to healthcare quality, NQF identified that some gaps remain in certain measure categories: (1) patient safety (especially for settings other than hospitals), (2) patient and family engagement, (3) healthy living, (4) care coordination, (5) affordability, and (6) prevention and treatment of leading causes of mortality. The report also highlights the need for measures of population health, person- and family-centered care, and for measures of the intersection of health information technology (HIT) and health care safety. With respect to measures of the *efficiency* of healthcare, NQF’s report also calls attention to the need for better measures of the price and cost of health care, noting that current measures focus on direct costs while excluding indirect costs that may be significant for persons and families, e.g., transportation to and from providers and lost income from missing work. NQF reports that much work remains to close the gaps in the set of endorsed measures currently available.

This report also calls attention to the need to increase our knowledge about how best to use measures of health care quality and efficiency. For example, as healthcare providers increasingly grapple with the need to accommodate patient differences including patient preferences, social, cultural, economic, and demographic factors in order to help people be healthy and safe, public reporting and value based payment programs also need to understand the extent to which (and if so, how) sociodemographic factors should be

incorporated into their quality measurements. Similarly, NQF's committee studying the use of episode groupers affirmed their value to performance measurements, but also concluded that endorsement of any particular episode grouper is not yet possible and set forth an agenda for additional work.

These complexities in the science of measurement are mirrored by the complexities faced by consumers when using quality and efficiency measures to select health plans and providers. The NQF project undertaken to provide input on the measures and the hierarchy for HHS' proposed Quality Rating System to help consumers select qualified health plans through Health Insurance Marketplaces documented the need for such rating systems to pay attention not just to *what* measures should be presented to consumers, but also *how* the measures should be displayed to consumers. It documented the need for such efforts to test all aspects of information displays with diverse populations, to incorporate provider-level quality information within health plan quality information, to provide functionality that allows consumers to customize and prioritize information to assist in their unique decision-making processes; and for such rating systems to continue to evolve as new measures are developed. Accomplishing this will help HHS provide better information to consumers for informing their choices about qualified health plans in the Marketplaces.

Increasing the number and comprehensiveness of endorsed measures, producing new knowledge to inform how best to deploy such measures, and making measures of quality and efficiency readily available and understandable to all stakeholders are critical components of HHS' work in strengthening the health care delivery system and helping people stay healthy and safe. HHS recognizes the success of the National Quality Forum in bringing together diverse stakeholders and fostering consensus to advise HHS' efforts in these areas. In addition, we appreciate the many people who participate in NQF's consensus projects by contributing their time and expertise in quality measurement. In this report, NQF notes that just one of its projects—the public-private Measure Applications Partnership (MAP), which provides input on the selection of performance measures for more than 20 Medicare public reporting and performance-based payment programs—now involves approximately 150 healthcare leaders and experts from nearly 90 private-

sector organizations as well as liaisons from seven different federal agencies.

Stakeholders convened by NQF include entire communities as well. Participants in the population health initiative undertaken by NQF on behalf of HHS include the Colorado Department of Health Care Policy and Financing; the Community Service Council of Tulsa, Oklahoma; the Designing a Strong and Healthy NY (DASH-NY) coalition of New York, NY; the Empire Health Foundation of Spokane, Washington; the Kanawha Coalition for Community Health Improvement of Charleston, West Virginia; Mercy Medical Center and Abbe Center for Community Mental Health—A Community Partnership with Geneva Tower, Cedar Rapids, Iowa; the Michigan Health Improvement Alliance of Central Michigan; Oberlin Community Services and The Institute for eHealth Equity, in Oberlin, Ohio; Trenton Health Team, Inc., in Trenton, New Jersey; and The University of Chicago Medicine Population Health Management Transformation initiative.

Such coalitions remind us that it takes all stakeholders working together to achieve better health care and health.

HHS thanks the NQF for this past year's work and for bringing together diverse stakeholders to achieve consensus in key performance measurement areas. We look forward to continuing to work together to advance the science and achieve the benefits of performance measurement.

IV. Future Steps

NQF annually undertakes several activities which constitute a recurring agenda. These include, for example, the endorsement and maintenance of standardized health care performance measures and making recommendations on measures under consideration by HHS for use in its many Medicare quality reporting and payment programs. In the coming year, in addition to the work on these ongoing annual projects, HHS will closely follow the progress of several special projects underway by NQF. In particular, NQF's two-year trial period which will test specific recommendations for attending to potential socioeconomic and sociodemographic factors in quality measurement is of interest. This project, added to analyses already underway by HHS in response to the *Improving Medicare Post-Acute Care Transformation Act of 2014* will provide a better understanding of how to address these factors in quality measurement, reporting and payment policy.

A second NQF special project focusing on population health, including community action to promote healthy living, will also contribute to the knowledge base of how to address social determinants of health as we seek to create a health care system that promotes prevention and wellness and keeps people healthy. This project also responds to one of the CBE duties (specified at Section 1890(b)(7)(a)(ii) of the Act) which requires the CBE to convene multi-stakeholder groups to provide input on national priorities for improvement in population health as identified in the national strategy. Specifically, one of the national strategy's three aims is to: "Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care." And one of the NQS' six priorities calls for "Working with communities to promote wide use of best practices to enable healthy living." To successfully address this aim and priority, multi-stakeholder input is needed on how federal, state and local governments and private sector community stakeholders can most effectively engage in:

1. "Supporting proven interventions to address behavioral, social, and environmental determinants of health;" and
2. "Working with communities to promote wide use of best practices to enable healthy living."

Other special projects to address gaps in measures for people dually eligible for Medicaid and Medicare services, and people who use long term care services and supports are also of great interest. HHS also will be following the progress of a special project to achieve greater consistency in the definitions of some of the data elements that comprise measures derived from electronic health records. Having consistent definitions of these data elements will enable these measures to perform more reliably, and promote more efficient assessment, endorsement and maintenance of measures derived from electronic data sources.

HHS will also seek to address gaps in measures identified in NQF's report, as HHS pursues new measure development and application in its value-based purchasing, public reporting, and other quality measurement and improvement initiatives.

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 24, 2015.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

¹ Throughout this report, a summary of the relevant statutory language appears in italicized text.

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