FOR FURTHER INFORMATION CONTACT: Ms. Andrea Krull, Public Health Advisor, National Vaccine Program Office, Department of Health and Human Services, Room 715H Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. Phone: (202) 690–5566; Fax: (202) 260–1165: e-mail; *nvpo@hhs.gov*.

Dated: September 3, 2009.

Bruce Gellin,

Deputy Assistant Secretary for Health, Director, National Vaccine Program Office.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

[HHS–XXXX–N]

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

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

ACTION: Notice.

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

FOR FURTHER INFORMATION CONTACT: Patrick Conway, (202) 690–7858.

I. Background

Rising health care costs coupled with the growing concern over the level and variation in quality and efficiency in the provision of health care raise important challenges for the United States. Congress mandated the Secretary of the Department of Health and Human Services (HHS) to contract with a consensus-based entity regarding performance measurement to support HHS' efforts to achieve value as a purchaser of high-quality, patient-centered, and financially sustainable health care. Section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added section 1890 to the Social Security Act (the Act). The statute mandates that the contract shall be competitively awarded for a period four years and may be renewed under a subsequent competitive contracting process.

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

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

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

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

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

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

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

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

Annual Report to Congress and the Secretary—Under section 1890(b)(5)(A) of the Act, by not later than March 1 of each year (beginning with 2009), NQF shall submit to Congress and the Secretary of HHS an annual report. The report shall contain a description of the implementation of quality measurement initiatives under the Act and the coordination of such initiatives with quality initiatives implemented by other payers; a summary of activities and recommendations from the national strategy and priorities for health care performance measurement task; and a discussion of performance by NQF of the duties required under the HHS contract. Due to the award of the contract to NQF in mid January 2009, the first annual report covers the performance period of January 14, 2009 to February 28, 2009.

In March 2009, NQF submitted the annual report to Congress and the Secretary of HHS. Section 1890(b)(5)(B) of the Social Security Act, as created by section 183 of MIPPA, requires the Secretarial review of the annual report to Congress upon receipt and the publication of the report in the **Federal Register** together with any Secretarial comments not later than 6 months after receiving the report. This notice complies with the review and publication requirements of the statutory mandate.

First NQF Report to Congress and HHS Secretary

Submitted in March 2009, the first annual report to Congress and the Secretary spans the period of January 14, 2009 to February 28, 2009. The first annual report reflects six weeks post contract award. Given the short timeframe between the contract award and the requirement for the annual report, it reflects a description of the NQF work-to-date as of March 2009 and future plans to comply with the schedule of deliverables. Additional

time under the contract will provide NQF the opportunity to report on its specific activities and deliverables provided to HHS in the next annual report and future annual reports. A copy of NQF's submission of the March 2009 annual report to Congress and the Secretary of HHS can be found at: *http://www.qualityforum.org/projects/ongoing/hhs.* The NQF annual report is reproduced in section III of this notice.

II. NQF March 2009 Annual Report

Improving Health Care Performance:

Setting Priorities and Enhancing Measurement Capacity

Report to Congress and the Secretary of the U.S. Department of Health and Human Services

Covering the Period of January 14, 2009 to February 28, 2009

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

Section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandates a Department of Health and Human Services (HHS) contract with a consensus-based entity regarding performance measurement (Section 1890 of the Social Security Act (the Act)). The National Quality Forum (NQF) was awarded the HHS contract through a competitive contracting mechanism to serve as the consensus-based entity. The statute mandates the submission of an annual report to both Congress and the Secretary of Health and Human Services by the consensus-based entity awarded the HHS contract (Section 1890(b)(5)(A) of the Act). The statute specifically requires the Secretarial review of such report upon receipt and the publication of such report in the **Federal Register** together with any Secretarial comments not later than 6 months after receiving the report (Section 1890(b)(5)(B) of the Act). This report was prepared by NQF. The report does not necessarily reflect the views of HHS. All HHS comments on this report will be provided at the time of its publication in the **Federal Register**. This report is part of contract number HHSM–500–2009–00010C. National Quality Forum, 601 Thirteenth Street, NW., Suite 500 North, Washington, DC 20005, Fax 202–783–3434, *http://www.qualityforum.org.*

Executive Summary

There is widespread and growing awareness from all levels of government that health care reform is a critical component of economic recovery—and that reform must address health care quality, safety, costs, access, and disparities in care. Truly better quality of care—care that is more effective, safe, and efficient—is an imperative for aiding our nation's economic recovery and making good on our commitment to cover the uninsured.

Numerous efforts are under way to advance the quality improvement agenda. These include the pay-for-performance and pay-for-reporting initiatives being undertaken by public and private sector purchasers; public reporting of performance information by the Centers for Medicare & Medicaid Services (CMS), State governments, and others; quality oversight by regulatory, accreditation, and professional certification bodies; and quality improvement activities being conducted by CMS' quality improvement organizations (QIOs), End-Stage Renal Disease Network Organizations, health care providers, practitioners, and others.

The overarching goal of all of our work is to improve the quality and affordability of health care by providing information to consumers and others to assist them in making more informed health care decisions, and to providers and practitioners to drive quality improvement. Measuring health care performance and then sharing those results with those who provide services and those who purchase and receive them are the cornerstones of a system that fosters not just incremental gains, but continued large-scale quality improvement.

Performance information is needed to support quality improvement, reform payment programs to promote value, and engage patients in making better choices and managing their health conditions. Performance measurement is a key building block for improving the quality of care.

Recognizing the need to strengthen the nation's performance measurement capacity, Congress included a provision within the Medicare Improvements for Patients and Providers Act of 2008 (PL 110–275), directing the Secretary of the Department of Health and Human Services (DHHS) to contract with a ''consensus-based entity, such as the National Quality Forum.'' The entity shall:

- Synthesize evidence and convene key stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings.
- Provide for the endorsement of standardized health care performance measures.
- Establish and implement a process to ensure that measures endorsed are updated (or retired if obsolete) as new evidence is developed.
- Promote the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information.
- Submit an annual report to Congress and the Secretary.

Under the contract, DHHS has asked that measures focus on ''outcomes and efficiencies that matter to patients, align with electronic collection at the front end of care, encompass episodes of care when possible, and be attributable to providers where possible. A premium must be placed on developing measures in key areas that will have the greatest impact in improving quality and value, rather than focusing on developing a large number of measures that may be easiest to produce, such as process measures.'' On January 14, 2009, the National Quality Forum (NQF) was awarded a contract that addresses and is responsive to Section 183 of the Medicare Improvements for Patients and Providers Act of 2008. The contract, which has a period of performance of four years, is being incrementally funded on a yearly basis.

As a part of its work under the contract, NQF is required to produce an Annual Report to Congress by March 1 each year. Because this contract only recently commenced on January 14, 2009, this initial report to Congress provides a ''look forward.'' More specifically, it focuses on two areas:

- Recent accomplishments that provide a foundation for work under this contract, and
- Strategic direction and key challenges that lie ahead.

Foundation for Work: Background and Recent Accomplishments

NQF is a not-for-profit, multi-stakeholder membership organization whose mission is to improve the quality of American health care by:

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

NQF's membership includes more than 375 organizations representing virtually every sector of the health care system. The work to be conducted under this DHHS contract will directly relate to NQF's core competencies and recent accomplishments in three areas:

- Setting National Priorities and Goals. NQF has convened leaders from major stakeholder groups and through this process has identified National Priorities and Goals for Performance Improvement. This work provides a foundation for the priority-setting efforts under this contract which focus on clinical conditions.
- Endorsing performance measures. NQF's consensus development process has resulted in more than 400 endorsed measures.
- Facilitating the development of electronic health records to support measurement and improvement. NQF has worked to identify the types of information that need to be included in an EHR to enable reporting on quality metrics.

Setting National Priorities and Goals

The National Priorities Partnership, convened by NQF, is a collaborative effort of 28 major national organizations representing multiple stakeholders, including consumer groups, employers, government, health plans, health care organizations, health care professionals, accrediting and certifying bodies, and quality alliances. The Partnership set National Priorities and Goals intended to focus performance improvement efforts on high-leverage areas—those with the most potential in the near term to result in substantial improvements in health and health care—and thus accelerate fundamental change in our health care delivery system. Taking action on the high-leverage Priorities and Goals, the Partners, individually and collectively, have the capacity to significantly advance health care reform. In November 2008, the Partnership released the results of its initial work in a report: National Priorities and Goals: Aligning our Efforts to Transform America's Health Care (see Appendix A for the executive summary).

The National Priorities and Goals were selected because they address four major challenges: Eliminating harm, eradicating disparities, reducing disease burden, and eliminating waste. The National Priorities fall into six areas:

- Engage patients and families in managing their health and making decisions about their care.
- Improve the health of the population.
- Improve the safety and reliability of America's health care system.
- Ensure patients receive well-coordinated care within and across all health care organizations, settings, and levels of care.
- Guarantee appropriate and compassionate care for patients with life-limiting illnesses.
- Eliminate overuse while ensuring the delivery of appropriate care.

The Partners are now developing action plans to achieve the National Priorities and Goals, which will entail alignment of key environmental drivers, such as public reporting, payment, and accreditation and certification programs. Learn more at *http://www.nationalprioritiespartnership.org*.

Endorsing Performance Measures

Advancing quality improvements requires valid, meaningful measurement. Simply put, you cannot improve what you cannot measure. Measures make it possible to more effectively focus our quality improvement efforts by helping identify what is working and what needs additional improvement. NQF is a private sector, standard-setting organization, and one of its roles is to evaluate measures and select the ''best in class.'' Use of NQF-endorsed® measures facilitates making apples-to-apples comparisons.

NQF is a voluntary consensus standard-setting organization as defined by the National Technology Transfer and Advancement Act of 1995 (NTTAA) and the Office of Management and Budget Circular A–119. Standard-setting organizations recognized under NTTAA must comply with strict requirements pertaining to multi-stakeholder involvement, transparency of decisionmaking, and due process.

The consensus development process (CDP) is the formal process by which NQF achieves consensus and endorses measures. There are seven steps in the endorsement process: Formation of a steering committee, calls for measures, measure evaluation, public comment, member voting, review by the consensus standards approval committee and board of directors, and appeals. The CDP reflects a careful process designed to produce consensus from disparate groups across the health care industry, including consumers, purchasers, providers, public and community health, suppliers, quality improvement and measurement organizations, and health plans.

Using this process, NQF has endorsed more than 400 quality measures for a variety of health care settings.

In 2008, NQF conducted consensus development projects in the following areas:

- Perinatal Care;
- Home Health Care;
- Ambulatory Care;
- Emergency Care;
- Health Information Technology;
- Hospital Care;
- Immunization;
- Outpatient Imaging.

Much of the support for these projects was provided by CMS and the Agency for Health care Research and Quality (AHRQ), as well as private foundations.

Facilitating the Development of Electronic Health Records To Support Measurement and Improvement

NQF also serves as an important ''bridge'' between the quality and health information technology communities to facilitate the development of electronic health records (EHRs) and personal health records (PHRs) that are capable of supporting performance measurement, reporting, and improvement. That work has two objectives. First, performance measures need to have turnkey measurement specifications that allow ready incorporation directly into EHRs and PHRs. Second, EHRs and PHRs must be able to capture the necessary data and possess the necessary functionality to calculate and report the performance information and provide the associated clinical decision-support to practitioners to improve performance.

NQF's Health Information Technology Expert Panel (HITEP), funded with support from AHRQ, produced its first report in January 2009 Recommended Common Data Types and Prioritized Performance Measures for Electronic Health Care Information Systems (see Appendix B for the executive summary). This report identifies the types of data that must be captured in EHRs to calculate the performance measures that are currently used by Medicare for public reporting purposes. Through its measure endorsement process, NQF is working with measure developers to encourage the adoption of common conventions for specifying measures that will make it easier for vendors to build EHRs and PHRs capable of calculating the measures and providing the associated clinical decision-support to assist providers in improving their performance. HITEP is now working closely with the DHHS Office of the National Coordinator to ensure that the ''Quality Data Set''—the types of data that need to be captured in EHRs and PHRs to support quality measurement and performance improvement—gets translated into health information technology standards, which in turn

become requirements for EHR certification by the Certification Commission for Health Information Technology.

Strategic Direction and Challenges Ahead

NQF has for many years received federal support, primarily in the form of grants and contracts for very specific projects (*e.g.*, a project to review physician-level measures related to cancer care). This new DHHS contract supports development and execution of a comprehensive, multi-year work plan for performance measurement. This contract will bolster, very significantly, six key functions of the quality measurement infrastructure.

Further Enhance the National Priorities and Goals. The current set of National Priorities and Goals represents cross-cutting areas that apply to all or many patients and conditions, like safety and care coordination. Over the coming year, a prioritized list will be developed of the top 20 conditions that account for 90 percent of Medicare costs, based on various criteria, including health and cost burden and opportunity for improvement. This two-dimensional framework—cross-cutting areas and conditions—will be used to focus the work of both NQF and other key players to achieve rapid improvement.

Building Measure Sets for Patient-Focused Episodes. Over the coming two to three years, measure sets will be identified for each of the top 20 conditions that include measures of the health care process (*e.g.*, effectiveness and safety measures), patient engagement, in decision making, patient outcomes, and cost. This framework moves the measurement field from a focus on the provision of individual services provided in one setting to an ''episode'' view that fosters patient engagement care coordination, efficiency, and accountability for outcomes.

Identify Critical Gaps in Measures. Measures will be needed to gauge progress in meeting the National Priorities and Goals, and efforts are now under way to identify gaps in the portfolio of NQF-endorsed measures. The mapping of available measures to conditions/patient-focused episodes will also reveal gaps.

Identify Areas for New Measure Development. Based on the ''gap analysis'' discussed above, an environmental scan will be conducted to determine if measures are available for endorsement or whether new ones need to be developed and which measures may be of most importance to the Medicare, Medicaid, or CHIP populations. There is also a significant need to identify where composite measures (combinations of two or more individual measures to produce an overall score) should be developed to provide an overall indication of performance in particular areas (*e.g.*, preventive services, safety).

Measure Maintenance and Retooling. The ability to examine measures on an ongoing basis with built-in requirements for regular measure maintenance helps ensure that the best measures are available for public reporting, health care performance assessment, and quality improvement. Performance measures must be maintained to reflect new clinical evidence, as well as ''lessons learned'' from their use in the field. NQF requires that measures undergo maintenance on a three-year cycle, or sooner if necessary. There is also a critical need to retool measures to run off of electronic data sources (*e.g.*, EHRs, administrative data, registries).

Further Strengthen Relationships Between the Quality Community and the Health Information Technology Community. NQF will foster ongoing communication and collaboration between the performance measurement community and the health information technology community, and ensure proper coordination of standard-setting activities that occur in the quality community (*e.g.*, standards related to clinical concepts, performance measure logic, and performance measure specifications) and standard-setting activities that occur in the HIT community (*e.g.*, EHR standards for data capture, data transmission protocols).

The goals of this contract will also support key HHS work outlined in the recently enacted American Recovery and Reinvestment Act of 2009 (ARRA) in three important ways.

- Work will support the health information technology (HIT) provisions of the ARRA by facilitating communications between the HIT and quality communities to ensure that electronic health records (EHRs) and personal health records (PHRs) possess the necessary capabilities to support performance measurement, reporting and improvement. NQF's work will be of relevance to both of the HIT Policy and Standards Committees that will be established under this law.
- The prevention provisions of ARRA call for strategies to reduce health care-associated infections and to enhance chronic disease outcomes. Through the priority-setting process, the NQF contract will focus performance improvement activities on these areas, and will identify standardized performance measures that can be used for public reporting and to assess the effectiveness of these programs.
- The comparative effectiveness research program of ARRA will provide new evidence on what treatments work and do not work to inform providers and consumers to use the best care available. Through its priority-setting and endorsement processes, NQF will likely identify key gaps in the evidence base, and this information will be shared with the comparative effectiveness program to help guide its agenda-setting activities.

Conclusion

Health care is going through a period of extraordinary change with efforts aimed at major reform of the health system. NQF is working closely with DHHS to ensure that the work under this contract provides the greatest value and support for health care reform that will give more people access to high quality, affordable health care.

This new contract will produce tangible benefits that are critical to establishing the measurement and reporting infrastructure necessary to achieve broader health reform objectives. Identifying national priorities for performance improvement, and measuring and reporting on the performance of health plans, health care providers, and practitioners against robust uniform national standards, will provide the needed foundation for achieving better patient outcomes, improved patient experience, and more affordable health care.

This contract will help establish a comprehensive portfolio of quality and efficiency measures that will allow the federal government to more clearly see how and whether health care spending is achieving the best results for patients and taxpayers, strengthening a core building block of the nation's capacity to provide high-value health care.

Appendix A—Report of the National Priorities Partnership National Priorities and Goals: Aligning our Efforts To Transform America's Health care (Executive Summary)

The Partners & Acknowledgements

The Partners

Donald Berwick, Co-chair President and CEO, Institute for Health Care Improvement

Margaret O'Kane, Co-chair President, National Committee for Quality Assurance

Leah Binder, Chief Executive Officer, Leapfrog Group

Christine Cassel, President and CEO, American Board of Internal

Medicine Representing the American Board of Medical Specialties
Mark Chassin, President, The Joint Commission
Carolyn Clancy, Director, Agency for Health Care Research and Quality
Janet M. Corrigan, President and CEO, National Quality Forum
Helen Darling, President, National Business Group on Health
Steven Findlay, Managing Editor, Consumer Reports Best Buy Drugs, Consumers Union
Roger Herdman, Director, National Cancer Policy Forum and Board on Health Care Services, Institute of Medicine
Julie Gerberding, Director, Centers for Disease Control and Prevention
George Isham, Medical Director and Chief Health Officer, HealthPartners Representing America's Health Insurance Plans
Peter V. Lee, Executive Director, National Health Policy, Pacific Business Group on Health
Marlene Miller, Vice Chair, Quality and Safety, Johns Hopkins Children's Center Representing the Alliance for Pediatric Quality
Mark McClellan, Director, Engelberg Center for Health Care Reform, Brookings Institution
Elizabeth Nabel, Director, National Heart, Lung, and Blood Institute, National Institutes of Health
Debra L. Ness, President, National Partnership for Women & Families
Frank Opelka, Vice-Chancellor of Clinical Affairs, Health Sciences Center, Louisiana State University Representing AQA
Alisa Ray, Executive Director, Certification Commission for Health Care Information Technology
Bernard Rosof, Chair, Physician Consortium for Performance Improvement
John Rother, Executive Vice President, Policy and Strategy, AARP
Raymond Scheppach, Executive Director, National Governors Association
Gerald Shea, Assistant to the President for External Affairs, AFL–CIO
David M. Stevens, Director, Quality Center, National Association of Community Health Centers
Linda J. Stierle, Chief Executive Officer, American Nurses Association
Barry Straube, Director and Chief Medical Officer, Centers for Medicare & Medicaid Services
Richard J. Umbdenstock, President and CEO, American Hospital Association Representing the Hospital Quality Alliance
Anthony Wisniewski, Executive Director, Health Care Policy, U.S. Chamber of Commerce

Key Staff
Karen Adams, Vice President, National Priorities
Alicia Aebersold, Vice President, Communications
Nadine Allen, Administrative Assistant
Anisha Dharshi, Program Director
Rebecca Fleischauer, Media Campaign Coordinator
Amy Stern, Senior Director, National Priorities Outreach Efforts
Wendy Vernon, Senior Program Director, National Priorities

Acknowledgements

An undertaking as complex and visionary as setting National Priorities and Goals for the nation clearly requires much thought, much expertise, much knowledge, and much work. The Partners first wish to acknowledge all of the reports and research and all of the efforts of the commissions and study groups that preceded and informed our work, many of which the reader can find in the references. We humbly recognize that our work stands on the shoulders of hundreds of brilliant people, both from within and outside of the health care arena, who are working every day to improve the way we deliver care. They cannot possibly all be listed, but their contributions are more than significant.

The Partners divided into a number of working groups to accomplish the work of the Partnership. We wish to thank the following experts who contributed significantly to our deliberations: Stephanie Alexander (Premier, Inc.), Carmella Bocchino (America's Health Insurance Plans), Kent Bottles (Institute for Clinical Systems Improvement), Maureen Corry (Childbirth Connection), Jay Crosson (Council of Accountable Physician Practices), Rita Munley Gallagher (American Nurses Association), Lea Anne Gardner (American College of Physicians), Paul Gitman (North Shore Long Island Jewish Health System), Trent Haywood (VHA, Inc.), Richard Hellman (American Association of Clinical Endocrinologists), Ronald A. Henrichs (American Academy of Dermatology), Michelle Johnston-Fleece (American Board of Internal Medicine), Norman Kahn (Council of Medical Specialty Societies), David Kindig (University of Wisconsin-Madison, School of Medicine), Jerod Loed (The Joint Commission), Michael Maciosek (HealthPartners Research Foundation), John Mastrojohn III (National Hospice and Palliative Care Organization), Kristen McNiff (American Society of Clinical Oncology), Diane Meier (Center To Advance Palliative Care), David Meyers (Agency for Health Care Research and Quality), Sean Morrison (National Palliative Care Research Center), Naomi Naierman (American Hospice Foundation), Harvey Neiman (American College of Radiology), Marsha Nelson (American Hospice Foundation), Lee Partridge (National Partnership for Women and Families), Robert Plovnick (American Psychiatric Association), Leif Solberg (HealthPartners Research Foundation), James Tulsky (Duke University, Center for Palliative Care), Margaret Van Amringe (The Joint Commission), and W. Douglas Weaver (American College of Cardiology). We wish to thank Michael Lauer (National Institutes of Health), Brad Perkins (Centers for Disease Control and Prevention), and Ed Sondik (Centers for Disease Control and Prevention) for their many contributions to this effort in support of their respective primary representatives on the Partnership.

We also would like to acknowledge the contributions of National Quality Forum Members for their input on the determination of the priorities and their concerted efforts to improve care coordination. Special thanks go to the chairs of the National Quality Forum Member Councils, including Paul Convery (Baylor Health Care System), Louis Diamond (Thomson Reuters), David Domann (Johnson and Johnson Health Care Systems), David Gifford (Rhode Island Department of Health), Robert Haralson (American Academy of Orthopaedic Surgeons), Christine Izui (BlueCross BlueShield Association), Brian Lindberg (Consumer Coalition for Quality Health Care), and Andrew Webber (National Business Coalition on Health). Dwight McNeill, Vice President for Education and Outreach, deserves recognition for his leadership of these efforts. We wish to acknowledge the input from the following NQF member nursing associations as well as the broader nursing community: American Nurses Association (ANA), American Association of Nurse Anesthetists, American Academy of Nursing, American Association of Colleges of Nursing, Hartford Institute for Geriatric Nursing, Infusion Nurses Society, American Organization of Nurse Executives, Hospice and Palliative Nurses Association, AORN (the Association of periOperative Nurses), Academy of Medical-Surgical Nurses, American College of Nurse-Midwives,

Association of Women's Health, Obstetric and Neonatal Nurses, National Council of State Boards of Nursing, and the American Psychiatric Nurses Association. The National Quality Forum staff teams contributed tirelessly to this effort, led by Karen Adams, Vice President of National Priorities, and Alicia C. Aebersold, Vice President of Communications. We wish to recognize the hard work of Nadine Allen, Ciarra Day, Stacy Fiedler, Sands Hakimi, Sara Maddox, Jeff Patyk, Bryan Pruitt, Dan Rafter, Mariam Rauf, Leslie Reeder-Thompson, Amy Stern, and Katharine Torrey. Special thanks to Wendy Vernon and Rebecca Fleischauer, who did a remarkable job drafting and editing significant sections of the report. And to Anisha Dharshi for her support of the working groups and her meticulous proofing of the final report. We wish to thank Helen Burstin, Senior Vice President of Performance Measurement for her guidance throughout this process, her service to the working groups, and her many contributions to the content and editing of this report.

Thanks also to Suzanne Benoit, Gregg Roby Burrage, Susan Guyre, and Marjorie Tucker-Pfeiffer at Rings Leighton for their patience and skill in producing the report, and to the teams at GYMR and MS&L for their support in the overall effort.

Finally, the National Priorities Partnership acknowledges the generous support from the Robert Wood Johnson Foundation, whose vision for the future of America's health care gave us the freedom to imagine a destination for our nation that is both aspirational and achievable. We wish to thank Anne Weiss for her invaluable guidance and support for this initiative and Minna Jung, a communications strategist and guide of the highest caliber.

Executive Summary

National Priorities and Goals: Aligning Our Efforts To Transform America's Health Care

The promise of our health care system is to provide all Americans with access to health care that is safe, effective, and affordable. But our system as it is today is not delivering on that promise. In recent years, we have seen remarkable efforts that demonstrate how well health care organizations can do in delivering on this promise, but these examples stand out because they are the exception, not the norm. To improve our results, we must fundamentally change the ways in which we deliver care, and this will require focused and combined efforts by patients, health care organizations, health care professionals, community members, payers, suppliers, government organizations, and other stakeholders. The National Priorities Partnership—a collaborative effort of 28 major national organizations that collectively influence every part of the heath care system—is doing just that. The Partners, convened by the National Quality Forum to address the challenges of our health care system, represent multiple stakeholders drawn from the public and private sectors. These organizations believe that it will require the work of many to achieve the transformational change that is needed for the United States to have a high-performing, high-value health care system. Recent economic events, including instability of the U.S. economy and what appears to be a wide and deep recession, make addressing our health care problems even more urgent. Many Americans have seen their retirement savings decline markedly, and millions of others have lost their homes and jobs. It is clear that the health care status quo is unsustainable. Health care spending accounts for 16 percent of the GDP (gross domestic product) and is increasing at an average annual rate of around 7 percent. Americans spend more per capita on health care than any other industrialized country, yet our results on many important indicators of quality fall significantly below those of similar nations. The time for serious and transformational change is now. As a first step, the Partners have identified a set of National Priorities and Goals to help focus performance improvement efforts on high-leverage areas—those with the most potential to result in substantial improvements in health and health care—and thus accelerate fundamental change in our health care delivery system.

The National Priorities and Goals

The National Priorities and Goals were selected because they collectively and individually address four major challenges—eliminating harm, eradicating disparities, reducing disease burden, and removing waste—that are important to every American. Six Priority areas have been identified in which the Partners believe our combined and collective efforts can have the most impact. While the Goals are aspirational, the success of many small scale improvement projects offers direction on how we might proceed to bring this to scale nationally.

Engage Patients and Families in Managing Their Health and Making Decisions About Their Care

We envision health care that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances, and differing cultures, languages and social backgrounds. The Partners will work together to ensure that: All patients will be asked for feedback on their experience of care, which health care organizations and their staff will then use to improve care. All patients will have access to tools and support systems that enable them to effectively navigate and manage their care. All patients will have access to information and assistance that enables them to make informed decisions about their treatment options.

Improve the Health of the Population

We envision communities that foster health and wellness as well as national, state, and local systems of care fully invested in the prevention of disease, injury, and disability—reliable, effective, and proactive in helping all people reduce the risk and burden of disease.

The Partners will work together to ensure that: All Americans will receive the most effective preventive services recommended by the U.S. Preventive Services Task Force. All Americans will adopt the most important healthy lifestyle behaviors known to promote health. The health of American communities will be improved according to a national index of health.

Improve the Safety and Reliability of America's Health Care System

We envision a health care system that is relentless in continually reducing the risks of injury from care, aiming for ''zero'' harm wherever and whenever possible—a system that can promise absolutely reliable care, guaranteeing that every patient, every time, receives the benefits of care based solidly in science. We envision health care leaders and health care professionals intolerant of defects or errors in care, and who constantly seek to improve, regardless of their current levels of safety and reliability. The Partners will work together to ensure that:

All health care organizations and their staff will strive to ensure a culture of safety while driving to lower the incidence of health care-induced harm, disability, or death toward zero. They will focus relentlessly on continually reducing and seeking to eliminate all

health care-associated infections (HAI) and serious adverse events. Health care-associated infections include, but are not limited to:

Catheter-associated blood stream infections
Catheter-associated urinary tract infections
Surgical site infections
Ventilator-associated pneumonia

(See the Centers for Disease Control and Prevention's Infectious Diseases in Health Care Settings for a more inclusive list.)

Serious adverse events include, but are not limited to:

Pressure ulcers
Wrong site surgeries
Falls Air embolisms
Blood product injuries
Foreign objects retained after surgery

Adverse drug events associated with high alert medications (See the National Quality Forum's Serious Reportable Events for a more inclusive list.)

All hospitals will reduce preventable and premature hospital-level mortality rates to best-in-class.

All hospitals and their community partners will improve 30-day mortality rates following hospitalization for select conditions (acute myocardial infarction, heart failure, pneumonia) to best-in-class.

Ensure Patients Receive Well-Coordinated Care Within and Across All Health Care Organizations, Settings, and Levels of Care

We envision a health care system that guides patients and families through their health care experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patients and the health care professionals accountable for their care. The Partners will work together to ensure that: Health care organizations and their staff will continually strive to improve care by soliciting and carefully considering feedback from all patients (and their families when appropriate) regarding coordination of their care during transitions.

Medication information will be clearly communicated to patients, family members, and the next health care professional and/or organization of care, and medications will be reconfirmed each time a patient experiences a transition in care.

All health care organizations and their staff will work collaboratively with patients to reduce 30-day readmission rates. All health care organizations and their staff will work collaboratively with patients to reduce preventable emergency department visits.

Guarantee Appropriate and Compassionate Care for Patients With Life-Limiting Illnesses

We envision health care capable of promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or dying, fully in synchrony with all of the resources that community, friends, and family can bring to bear at the end of life.

The Partners will work together to ensure that: All patients with life-limiting illnesses will have access to effective treatment for relief of suffering from symptoms such as pain, shortness of breath, weight loss, weakness, nausea, serious bowel problems, delirium, and depression.

All patients with life-limiting illnesses and their families will have access to help with psychological, social, and spiritual needs.

All patients with life-limiting illnesses will receive effective communication from health care professionals about their options for treatment; realistic information about their prognosis; timely, clear, and honest answers to their questions; advance directives; and a commitment not to abandon them regardless of their choices over the course of their illness.

All patients with life-limiting illnesses will receive high-quality palliative care and hospice services.

Eliminate Overuse While Ensuring the Delivery of Appropriate Care

We envision health care that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including tests, drugs, procedures, visits, and hospital stays.

The Partners will work together to ensure that:

All health care organizations will continually strive to improve the delivery of appropriate patient care, and substantially and measurably reduce extraneous service(s) and/or treatment(s).

The recommended areas of concentration are as follows:

Inappropriate medication use, targeting:
- Antibiotic use
- Poly pharmacy (for multiple chronic conditions; of antipsychotics)

Unnecessary laboratory tests, targeting:
- Panels (*e.g.,* thyroid, SMA 20)
- Special testing (*e.g.,* Lyme Disease with regional considerations)

Unwarranted maternity care interventions, targeting:
- Cesarean section

Unwarranted diagnostic procedures, targeting:
- Cardiac computed tomography (noninvasive coronary angiography and coronary calcium scoring)
- Lumbar spine magnetic resonance imaging prior to conservative therapy, without red flags
- Uncomplicated chest/thorax computed tomography screening Bone or joint x-ray prior to conservative therapy, without red flags Chest x-ray, preoperative, on admission, or routine monitoring Endoscopy

Inappropriate non-palliative services at end of life, targeting:
- Chemotherapy in the last 14 days of life
- Aggressive interventional procedures
- More than one emergency department visit in the last 30 days of life

Unwarranted procedures, targeting:
- Spine surgery
- Percutaneous transluminal coronary angioplasty (PTCA)/Stent
- Knee/hip replacement Coronary artery bypass graft (CABG)
- Hysterectomy
- Prostatectomy

Unnecessary consultations Preventable emergency department visits and hospitalizations, targeting:
- Potentially preventable emergency department visits
- Hospital admissions lasting less than 24 hours
- Ambulatory care sensitive conditions

Potentially harmful preventive services with no benefit, targeting:
- BRCA mutation testing for breast and ovarian cancer—female, low risk
- Coronary heart disease (CHD): Screening using electrocardiography, exercise treadmill test, electron beam computed tomography—adults, low risk
- Carotid artery stenosis screening—general adult population
- Cervical cancer screening—female over 65, average risk and female, post-hysterectomy
- Prostate cancer screening—male over 75 (From the U.S. Preventive Services Task Force D Recommendations List)vi

The Path Forward

Identifying a starter set of National Priorities and Goals is a major accomplishment, but it is only the first step in what must be a more expansive and ongoing implementation aimed at achieving the performance goals. Over the next year and beyond, we hope the National Priorities and Goals will spur action and innovation, because without coordinated actions, these goals will not be reached. The Partners have agreed to work with each other and with

policymakers, health care leaders, and the community at large, to build on the framework provided in this report, and to develop actions in each of the major areas that will drive improvements needed: Performance measurement, public reporting, payment systems, research and knowledge dissemination, professional development, and system capacity.

Health care reform is well under way and the current economic crisis makes solving the puzzles of quality, equity, and value not just an ideal, but an imperative. The National Priorities Partnership is encouraging everyone to join not in calling for reform, but in enacting it nationally and in local communities across the country. The mere existence of a shared sense of responsibility to meet specific goals can transform health care quality. Acting to meet them can revolutionize it.

i. Catlin A, Cowan C, Heffler S, *et al.,* National health spending in 2005: The slowdown continues. Health Aff, 2007;26(1):142–153.

ii. The Commonwealth Fund, ''Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008''.

iii. Centers for Disease Control and Prevention, Infectious Disease in Health care Settings. Available at *http://www.cdc.gov/ncidod/dhqp/id.htm.*

iv. National Quality Forum, Serious Reportable Events. Available at *http://www.qualityforum.org/projects/completed/srz/fact-sheet.asp.*

v. ''Best-in-class'' may be determined by using an accepted methodology, such as Achievable Benchmarks in Care (ABC)™.

vi. Agency for Health care Research and Quality, U.S. Preventive Services Task Force (USPSTF). Available at *http://www.ahrq.gov/clinic/prevenix.htm.*

The time for serious and transformational change is now.—The National Priorities Partnership

Appendix B—Report of the Health Information Technology Expert Panel: Recommended Common Data Types and Prioritized Performance Measures for Electronic Health Care Information Systems (Executive Summary)

As described in the Institute of Medicine's (IOM's) Crossing the Quality Chasm report, the quality of health care in the United States is substantially lacking in many pivotal areas. Complex care is typically uncoordinated, and important information is frequently unavailable when needed by providers. Consequently, unexplained variations in the delivery of health care and the underuse, overuse, and misuse of health care products and services pervade the system, compromising the quality of American medicine and jeopardizing the health of its recipients.

Measuring quality is a first step toward improving American health care. Currently, however, collecting and reporting accurate, comparative health care performance data is complex and largely a time-consuming, manual process. Quality improvement leaders have long recognized that the widespread adoption of health information technology (HIT) will automate and simplify these processes by providing electronic information. Yet, to date, most of the electronic health information readily available for quality measurement has been administrative, claims-based data, which include only limited clinical information.

Electronic health record (EHR) systems have been identified as a fundamental HIT tool for collecting high-quality electronic clinical information. The federal government and private sector leaders have increased efforts to expedite and encourage the widespread adoption of HIT by health care providers; yet significant barriers prevent the collection of needed quality information within the EHR. To compare performance nationally, all quality indicators need to measure the same concepts and speak the same language in order to consistently and reliably measure quality.

Although there is no dearth of HIT standards, such standards do not exist when defining quality metrics (*e.g.,* the definition of diabetes may be interpreted differently by different institutions). This lack of a set of precisely defined, universally adopted clinical definitions is an obstacle to measuring and comparing quality.

To address the need for standardization of health care quality measurement, the American Health Information Community (AHIC), an advisory committee to the Secretary of the Department of Health and Human Services (DHHS), established a Quality Workgroup to define how HIT can evolve to effectively support performance measurement. The workgroup recommended that an HIT expert panel be convened in order to accelerate ongoing efforts in this standardization process. The National Quality Forum (NQF) was commissioned by the Agency for Health care Research and Quality (AHRQ) to assemble and convene the expert panel and to provide a detailed account of its conclusions and recommendations. The NQF Health Information Technology Expert Panel (HITEP) members (Appendix A) were selected to ensure broad representation across the fields of quality measurement and HIT and of EHR vendors, health systems, and government organizations. With the goal of achieving automated quality measurement, the panel was charged with the following tasks:

1. Establish a priority order for the current sets of AQA Alliance—and Hospital Quality Alliance—approved measures;

2. Identify common data types from the subset of highest priority measures to be standardized for automation in EHRs and health information exchanges; and

3. Develop an overarching quality measure development framework to facilitate developing, using, and reporting on quality measures from EHR systems.

To prioritize measures for immediate attention, the panel used the IOM's priority conditions. Next, the panel identified the common data types (*e.g.,* outpatient diagnosis, laboratory result, medication order) required by these high-priority measures. The panel then developed a set of criteria (*e.g.,* level of data standardization, accuracy of data source) to assess the quality of each data type as it currently exists in EHRs. Each data type received a summary quality score from these criteria. Because measures are composed of numerous data types, the panel calculated overall scores for each measure as the average quality of its individual data types. This overall measure score can be used to assess a measure's readiness for EHR implementation and to focus efforts to improve (or replace) low-scoring measures and low-scoring data types. Although the work of HITEP was to establish an initial prioritization of measures and their associated data types, further data types should be identified as additional priorities and measures are developed.

A key product of the HITEP meetings, a list of common data types (*i.e.,* diagnoses, laboratories, medications), was submitted to the Health Information Technology Standards Panel (HITSP) for the selection of standard terminologies, or code sets (*i.e.,* ICD–9, LOINC, SNOMED), to express these data types. These computerized terminologies, identified in the HITSP Quality Interoperability Specification version 1.0, will support efforts for universal adoption of standardized performance measures in EHRs. Active engagement of standard development organizations by HITSP will aid in closing the gap between the quality and information technology enterprises. Additional

recommendations for EHR functionality will be submitted to the Certification Commission for Health Care Information Technology (CCHIT) for consideration in future certification criteria.

HITEP identified three broad requirements to improve the quality measurement information technology enterprise and suggested recommendations to CCHIT, HITSP, measure development organizations (MDOs), NQF, EHR vendors, and the HL7 EHR Technical Committee. First, quality measures should be designed to leverage the capabilities of EHRs. MDOs and NQF should work together to reinforce the use of high-quality data types during measure development and endorsement of measures into consensus national standards. Second, standard terminologies should be identified to code the common data types used in quality measure definitions. Finally, quality measure clinical information should be accurately captured in EHRs. Quality and information technology stakeholders should work with EHR vendors to develop functional criteria for software needed to capture the common data required for quality measurement.

Appendix C—Overview of the Tasks of the Contract

The contract consists of twelve tasks. The first five tasks involve overall contract management and include the development of a work plan and an internal quality assurance evaluation plan. A detailed work plan for the first year of the contract activities is under way. Tasks six through twelve represent the work of the contract. A brief synopsis of each task is provided below.

Task 6: Formulation of National Strategy and Priorities for Health Care Performance Measurement

NQF will 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. NQF will develop a framework for measure prioritization that will take into account the cost and prevalence of the conditions and the likelihood and ease of measurement to improve the quality, value and transparency of the performance of the health care system. This framework will identify those areas where no measures currently exist and will assist key stakeholders with the prioritization of those areas in which measure development may be required. NQF is currently developing a request for proposal to select a subcontractor, and under the guidance of NQF, will develop the framework and other documents that will assist with identifying critical measurement gap areas as well as prioritize those areas through endorsement of measures, reworking existing measures and/or measure development. This prioritization framework will help guide the future work of this contract and measurement priorities.

Task 7: Implementation of a Consensus Process for Endorsement of Health Care Quality Measures

NQF is a voluntary consensus standards-setting organization and has an established multi-stakeholder consensus development process to endorse measures appropriate for public reporting and quality improvement. The process involves seven steps specifically designed to develop consensus among diverse stakeholders: Formation of a steering committee, calls for measures, measure evaluation, public comment, member voting, review by the consensus standards approval committee and board of directors, and appeals. This process has been streamlined to better meet the needs of the health care industry. Using this process, NQF has endorsed more than 400 quality measures for a variety of health care settings. As part of this contract with DHHS, NQF will endorse measures and measure sets. These measures will focus on specific conditions and settings as well as across episodes of care.

Task 8: Maintenance of Consensus Endorsed Measures

As an endorsing body, NQF is responsible for maintaining endorsement of the consensus standards. Due to evolving research and implementation issues, measure maintenance is required by NQF every three years. This established process along with annual updates of the measure specifications ensures the relevancy of the endorsed measures to current health care practice. The ability to critically examine the measures on an ongoing basis with built-in requirements for regular measure maintenance provides a critical avenue to ensure that the best measures are available for public reporting health care performance and quality improvement.

Task 9: Promotion of the Electronic Health Records (EHRs)

EHRs have significant potential to improve the quality, coordination, and efficiency of patient care. In the context of performance measurement and improvement, they also have a critical role to play in collecting chart level clinical patient data, which may be reliably used in performance evaluation. The objective of this task is for performance measures to have turnkey measurement specifications that allow for ready incorporation directly into EHRs; and for EHRs to capture the necessary data and possess the necessary functionality to calculate and report the performance information and to provide the associated clinical decision-support to practitioners to improve performance. To achieve these goals, there needs to be ongoing communication and collaboration between the performance measurement community and the health information technology community. NQF is planning to convene these groups to streamline the performance measurement enterprise and to promote the use of EHRs to achieve the quality improvement goals of DHHS.

Task 10: Annual Report to Congress and the Secretary of the U.S. Department of Health and Human Services

This report will provide an update as to the progress of the tasks associated with the contract. NQF will use a structured system for data gathering and reporting, and on a monthly basis, will gather information for inclusion in the final report. The annual report will be available on the NQF Web site for public viewing after copies are submitted to the Secretary and to Congress.

Task 11: Development of a Public Web Site for Project Documents

NQF will provide electronic access on a public website to all of the project's final and revised reports, standard operating procedures for consensus-building and maintenance procedures, and working documents deemed necessary as part of their consensus-building processes for any and all tasks issued under this contract. Planning is underway for Web site layout and the Web site will ''go live'' in June 2009.

Task 12: Focused Measure Development, Harmonization, and Endorsement Efforts To Fill Critical Gaps in Performance

NQF is prepared to address measurement gaps identified in Task 6 of this contract in a timely, efficient, and effective manner. NQF will respond to up to ten requests annually to fill critical gap areas through measure endorsement, measure harmonization, measure restructuring, and measure development. NQF will subcontract with established measure developers to develop new measures, including composite measures and/or re-working

existing measures to fill critical gaps in measures of health care performance.

National Quality Forum, 601 Thirteenth Street, NW., Suite 500 North, Washington, DC 20005, Fax 202–783–3434, *http://www.qualityforum.org.*

III. Secretarial Comments on the Annual Report to Congress

The Secretary is pleased with the scope and vision of NQF's March 2009 annual report. The contract with this consensus-based entity, NQF, provides a unique opportunity to further enhance HHS' efforts to foster a collaborative, multi-stakeholder approach to increase the availability of national voluntary consensus standards for quality and efficiency measures to ensure broad transparency in achieving value in health care delivery. An internal multidisciplinary cross-component HHS team is working collaboratively with NQF to ensure a clear multi-year vision to ensure the most efficient and effective utilization of the HHS contract. HHS looks forward to the ongoing opportunity to collaborate with the broader health care community as part of this NQF contract to ensure a consensus-based national strategy and priority setting process for health care measurement focusing on high-quality, patient-centered, efficient health care delivery.

IV. Future Steps

The consensus based contract with NQF is a four year contract. During the first year of the contract, NQF shall complete deliverables for each task. HHS will task NQF with single year and multi-year projects.

Formulation of National Strategy and Priorities for Health Care Performance Measurement

During the first year of the HHS contract, NQF will create a framework for measurement prioritization by conducting an environmental scan of at a minimum, the 20 patient conditions that account for over 95% of costs to the Medicare program. NQF is establishing a steering committee to oversee the prioritization process.

Maintenance of Consensus Endorsed Measures

During the first year of the HHS contract, NQF is maintaining endorsed measures relevant to HHS-wide programs and will be maintaining consensus-based endorsed measures as developed under the priority process.

Promotion of Electronic Health Records

During the first year of the HHS contract, NQF is supporting the promotion of electronic health records and quality measurement incorporation as part of HHS-wide efforts.

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

During the first year of the HHS contract NQF is supporting a variety of performance measurement efforts including, but not limited to, the areas of efficiency, harmonization, outcomes, patient safety, care coordination, ICD–10, palliative care, and nursing home quality metrics.

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

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: September 3, 2009.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. E9–21783 Filed 9–4–09; 4:15 pm]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Head Start Program Administrative Practice and Procedure; Appeal Procedures, 45 CFR Part 1303.

OMB No.: 0980–0242.

Description: Section 646 of the Head Start Act requires the Secretary of Health and Human Services to prescribe a timeline for conducting administrative hearings when adverse actions are taken or proposed against Head Start and Early Head Start grantees and delegate agencies. The Office of Head Start is proposing to renew, without changes, this rule, which implements these requirements and which prescribes when a grantee must submit certain information and what that information shall include.

Respondents: Head Start and Early Head Start grantees and Delegate Agencies.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Rule	20	1	26	520

Estimated Total Annual Burden Hours: 520.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *infocollection@acf.hhs.gov.*

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, Fax: 202–395–7245, Attn: Desk Officer for the Administration for Children and Families.