



## GLOSSARY OF TERMS

Also see the [NQF Phrasebook](#) -a guide to NQF's most commonly used terms. It is an attempt to translate our jargon into plain English.

**Access** The ability to obtain needed healthcare services in a timely manner including the perceptions and experiences of people regarding their ease of reaching health services or health facilities in terms of proximity, location, time and, ease of approach. Examples may include, but are not limited to, measures that address timeliness of response or services, time until next available appointment, and availability of services within a community.

**Accountability** An obligation or willingness to accept responsibility for performance.

**Accountability Applications** - Use of performance results about identifiable, accountable entities to make judgments and decisions as a consequence of performance, such as reward, recognition, punishment, payment, or selection (e.g., public reporting, accreditation, licensure, professional certification, health information technology incentives, performance-based payment, network inclusion/exclusion).

**Accountability programs** - These programs vary in scope but all tie rewards to performance on quality measures. Accountability programs may also be referred to as incentive programs or high-stakes uses of measurement. When incentives such as payment and market competition are on the line, measurement programs have more impact and also come under more scrutiny.

**PRIVATE REPORTING:** sharing quality measurement results with internal stakeholders only, such as within a single health system

**PUBLIC REPORTING:** sharing quality measurement results with the general public, such as through a website or printed report.

**PERFORMANCE-BASED PAYMENT:** payment for care that is contingent on performance measurement results.

**MEANINGFUL USE OF HIT:** a well-known incentive program to expand the use of electronic health records. It allows eligible providers and hospitals to earn payments by meeting specific criteria regarding the use of electronic information to improve care.

**Ad Hoc Review** An ad hoc review may be conducted on an endorsed measure, practice, or event at any time with adequate justification to substantiate the review. Requests for ad hoc reviews will be considered by NQF on a case-by-case basis and must be justified by specific criteria. NQF can initiate an ad hoc review without an external request when material changes are made to a measure or emerging evidence suggests the need for a

review. The ad hoc review process follows a shortened version of the Consensus Development Process. If a measure remains endorsed after an ad hoc review, it is still subject to its original maintenance cycle.

**Administrative Claims** - Data derived from administering and/or reimbursing patient care.

**Adverse** - describes a consequence of care that results in an undesired outcome. It does not address preventability.

**Affordability, measurement** - Affordability is emerging as a high priority in performance measurement. Many terms related to this topic have subtle differences.

**Cost** - An amount, usually specified in dollars, related to receiving, providing, or paying for medical care. Things that contribute to cost include visits to healthcare providers, healthcare services, equipment and supplies, and insurance premiums.

Costs can be direct, such as when a person gives a copay at a pharmacy window. They can also be indirect, such as when poor health leads to lost productivity in the workplace.

**Resource Use** -Resources are the goods or services that are combined to produce medical care. They are inputs that have a price assigned to them. When a procedure is done many times, resource use can be measured and predicted. For example, the people and things needed to perform cataract surgery are a set of resources.

**Efficiency** - This concept combines cost and quality. At a given level of quality, services can be highly efficient or inefficient. Improved efficiency comes from providing high-quality healthcare at lower cost.

**Value** - The value of healthcare is subjective. It weighs costs against the health outcomes achieved, including patient satisfaction and quality of life.

**Agency for Healthcare Research and Quality (AHRQ)** – the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of and effectiveness of health care for all Americans.

**Ambulatory Care** - Healthcare services that do not require a hospital admission. These may be provided in an ambulatory surgery center, clinician office, or clinic/ urgent care setting.

**Ambulatory Surgery Center (ASC)** - Setting where outpatient surgical services are provided.

**Annual Measure Maintenance Update** On an annual basis, measure stewards are responsible for submitting information to NQF that affirms the detailed measure specifications of the endorsed measure have not changed or, if changes have been made, the details and underlying reason(s) for the change(s). A full review of the NQF evaluation criteria will occur only at the three-year review. The annual maintenance for measures is staggered throughout the year, and the process typically last one quarter (three months) to complete.

**Attribution**—identifying and assigning of a responsible provider or entity (e.g., health plan) for the care delivered for an episode or population.

**Behavioral Health/Psychiatric** Behavioral health/psychiatric services may include, but are not limited to, diagnostic, therapeutic, and preventive mental health services, therapy and/or rehabilitation for substance-dependent individuals, and the use of community resources, individual case work, or group work to promote the adaptive capacities of individuals in relation to their social and economic environments.

**Benchmarking**—the process of comparing the performance of accountable entities with that of their peers or with external best practice results. In developing comparative estimates, results should be risk adjusted for patient-level attributes to support the valid comparisons of these accountable entities.

**Burden** - While crucial to improving healthcare quality, measurement can have a downside: *it takes a lot of hard work!* Measurement burden can be the result of a number of factors, including costs and time associated with increased, duplicative, or labor-intensive data collection, analysis, or reporting.

**Parsimony** -Being parsimonious with measures means using only as many measures as necessary to meet a program’s goals – no more, no less. A negative view of parsimony is stinginess; a positive one is minimizing burden.

**Alignment** -Another way NQF is working to reduce the burden of measurement is by promoting alignment. Alignment is achieved when a set of measures works well across settings or programs to produce meaningful information without creating extra work for those responsible for the measurement. Alignment includes using the same quality measures in multiple programs when possible. It can also come from consistently measuring important topics across settings. NQF uses several tools to promote alignment including measure harmonization and identifying families of measures and core measure sets.

**Family of measures** -A family of measures is a group of measures that addresses an NQS priority or high-impact condition across various settings of care, type of data analysis, populations, or reporting programs. High priority measure gaps are also included when there are few or no measures to address important elements of care for a topic. NQF’s past work has defined families of measures for cardiovascular disease, diabetes, patient safety, and care coordination.

**Cancer** - Cancer may include, but is not limited to, bladder, breast, colorectal, gynecologic, hematologic, liver, lung, esophageal, pancreatic, prostate and skin.

**Cardiovascular** - Cardiovascular may include, but is not limited to, acute myocardial infarction, atrial fibrillation, congestive heart failure, hyperlipidemia, hypertension, ischemic heart disease, coronary artery disease, and percutaneous coronary intervention (PCI).

**Care Coordination** - Ensuring patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care. Examples may include, but are not limited to, measures that address care management across settings, care transitions, plan of care and follow up, and handoff communication.

**Care Setting** -Settings or services for which the measure applies and is assessed.

**Carve-outs**—the outsourcing of services, such as behavioral health or pharmacy claims, to specialty health plans or claims processing entities or organizations.

**Center for Medicare and Medicaid Services (CMS)** – The US federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program

**Children's Health** - Individuals aged 17 years and younger.

**Classification** - In QPS, NQF-endorsed measures are classified into several categories by which the user can search (care setting, conditions, cross-cutting area, data source, level of analysis, measure type, purpose/use, target population).

**Clinical hierarchy**—an arrangement of clinical conditions that are ranked according to severity, as “high,” “below,” or “at the same level.” For example, if a patient has COPD and develops bronchitis, COPD would be assigned a greater weight than bronchitis.

**Clinical practice guidelines** -Systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.

**Clinician** -Various types of healthcare practitioners/providers, which may include but is not limited to, physicians, nurses, and allied health professionals.

**Clinician Office** - Setting in which outpatient healthcare services are provided by physicians or other healthcare providers, including but not limited to, primary care, family practice, general internal medicine, and faculty practice plans.

**Clinic/Urgent Care** -Setting in which urgent care services are provided. Urgent care services are medically necessary services which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours.

**Code System / Code Set** - Sometimes using ordinary spoken or written language is not the easiest way to communicate – like when complex and technical health information needs to be shared system-wide. A code system is a way to turn health information like a diagnosis or procedure name into numbers or code to make sharing information easier and faster. A code set is a specific version of that system’s rules.

**Community** ( as a population) - A group of individuals within a community.

**Competing Measures** – Measure that have the same concepts for the measure focus (target process, condition, event, outcome) AND the same target population being measured

**Complex measure** – a measure that requires the use of a proprietary (non public domain) grouper, risk adjustment or other similar methodology that is essential to calculating the result of the measure.

**Complications** - Any harm (injury or illness) caused by medical care resulting in an undesirable clinical outcome. This includes measures that may address adverse events.

**Composite** - A combination of two or more component measures, each of which individually reflects quality of care, into a single performance measure with a single score.

**Condition** – Health conditions or topics intended to be measured.

**Consensus** (as defined by Office of Management and Budget) - general agreement, but not necessarily unanimity, and includes a process for attempting to resolve objections by interested parties, as long as all comments have been fairly considered, each objector is advised of the disposition of his or her objection(s) and the reasons why, and the consensus body members are given an opportunity to change their votes after reviewing the comments.

**Consensus Development Process** -- NQF uses its formal CDP to evaluate and endorse different types of consensus standards. Standards are most often performance measures. They can also include best practices, frameworks, and reporting guidelines. The CDP follows carefully delineated steps to balance the opinions of all stakeholders to reach consensus. The collection of measures and other resources resulting from CDP projects are sometimes called the *NQF portfolio*.

**Consensus standard** – a quality performance measure or practice that has been endorsed by NQF.

**Consensus Standards Approval Committee (CSAC)** - The Consensus Standards Approval Committee (CSAC) considers all candidate consensus standards recommended for endorsement by NQF. Members of the Committee possess breadth and depth of expertise in healthcare quality improvement and performance measurement and are drawn from a diverse set of stakeholder perspectives. After their detailed review of a candidate standard, the CSAC submits decisions regarding endorsement to the Board of Directors. The Board can affirm or deny CSAC's decisions.

**Cost of care** - a measure of the total healthcare spending, including total resource use and unit price(s), by payor or consumer, for a healthcare service or group of healthcare services, associated with a specified patient population, time period, and unit(s) of clinical accountability.

**Cost/Resource Use** - Counting the frequency of units of defined health system services or resources; some may further apply a dollar amount (e.g., allowable charges, paid amounts, or standardized prices) to each unit of resource use (i.e., monetize the health service or resource use units).

**Cross-Cutting Area** - Cross-cutting areas refer to broad topics that people are interested in measuring and improving across the healthcare system. Sometimes we think about high-quality healthcare in the context of a disease, such as cancer, and making the right choices for treatment. At other times we think about factors that affect everyone receiving healthcare regardless of disease, like how well doctors and nurses communicate with patients.

**Data element, critical** - Quality performance measures are based on many individual items of information. The data elements are often patient-level information on individual patients (e.g., blood pressure, lab value, medication, surgical procedure, death). Testing at the data element level should include those elements that contribute most to the computed measure score, that is, account for identifying the greatest proportion of the target condition, event, or outcome being measured (numerator); the target population (denominator); population excluded (exclusions); and when applicable, risk factors with largest contribution to variability in outcome. Structural measures generally are based on organizational information rather than patient-level data.

**Data element, quality** -A quality data element is a single piece of information that is used in quality measures to describe part of the clinical care process, including both a clinical entity and its context of use (e.g., diagnosis, active)

**Data Source** - Source(s) from which data are obtained for measurement.

**Data types** - A grouping of information that indicates the circumstance of use for any individual standard data type (e.g. outcome, process, composite)

**Denominator Statement** - A brief text description of the target population being measured.

**Dialysis Center** - Setting in which dialysis services are furnished to patients.

**Disparities** -Differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, or appropriateness of intervention. Examples may include, but are not limited to, measures that address variation in care related to race, ethnicity, socioeconomic status, sexual orientation, cognitive or physical disabilities, and age.

**Disparities-sensitive measure** - Performance measures identified as *disparities-sensitive* highlight inequalities in care. Measure results can be split, or *stratified*, to show whether there are differences between two or more groups. Once disparities are visible, targeted strategies can be developed to address them.

**Efficiency (Measure Type)** -The cost of care associated with a specified level of health outcomes.

**Efficiency of care** - a measure of cost of care associated with a specified level of quality of care. “Efficiency of care” is a measure of the relationship of the cost of care associated with a specific level of performance measured with respect to the other five IOM aims of quality.

**Electronic Clinical Data (Data Source)** -Data derived from a repository of electronically maintained information about healthcare.

**Electronic health record (EHR) system** - An electronic health record (EHR) is just like it sounds: a systematic collection of health information about a patient or population in a digital format. At its simplest, an EHR is a computerized version of a doctor’s traditional paper charts. Electronic information in EHRs can be more easily shared through connected systems and other information networks.

**EHR standards** - Healthcare providers use different types of EHR systems that need to be able to communicate, translate, and use information from many sources. Standards are sets of rules or guidelines that allow for interoperability (the exchange of useful data across different systems).

**eMeasure** - eMeasures are performance measures that have been developed for use in an EHR or other electronic system. eMeasures pull the information needed to evaluate performance directly from the electronic record. They can be far more efficient than traditional approaches of extracting data from paper charts or claims databases.

**Value set** - A value set is a list of specific clinical terms and the codes that correspond with them. A value set defines each of the clinical terms in the elements of a quality measure. Value sets support the calculation of eMeasures and the systematic exchange of health information.

**Empirical evidence:** -Data or information resulting from studies and analyses of the data elements and/or scores for a measure as specified, unpublished or published.

**Emergency Medical Services/Ambulance (Care Setting)** -First responder care specifically designed, equipped, and staffed for lifesaving procedures and transporting the sick or injured.

**Endocrine** -Endocrine may include, but is not limited to, diabetes and thyroid disorders.

**Endorsement Date** -The date that the measure was endorsed.

Endorsement Maintenance - Because healthcare is always changing, measures need ongoing maintenance and updates. Endorsement maintenance is a review process completed every three years to ensure that measures continue to meet the measure evaluation criteria and that their specifications are up to date. The endorsement maintenance process creates an opportunity to consider all available measures in a topical area, harmonize them and endorse the “best in class.”

**Endorsement Type** -There are three endorsement types: endorsed, time-limited endorsed, or endorsed with reserve status.

**ESRD** - End State Renal Disease

**Environmental scan** – systematic collection of external information to identify new ideas or concepts such as measures or practices

**Episode of care** - Treatment of many health conditions crosses time and place. An *episode of care* includes all care related to a patient’s condition over time, including prevention of disease, screening and assessment, appropriate treatment in any setting, and ongoing management.

**Event** - Event means a discrete, auditable, and clearly defined occurrence.

**Exclusions** -A brief text description of exclusions from the target population.

**Exclusion criteria**—criteria applied before a measure is tested in order to remove any individuals with conditions that may skew the final measure score.

**Facility (Level of Analysis)** -A single entity that provides healthcare, which may include but is not limited to, a hospital, nursing home, dialysis center, and home health agency.

**Feedback Loops** - Quality measurement is a constant work in progress. Feedback loops are a way to collect and share useful information. They can be used for healthcare quality measurement by identifying measures that need modification or areas where adequate measures are not available. Such an exchange of information promotes continuous learning and improvement across the entire healthcare system.

**Functional Status (Cross-Cutting Area)** -The level of activities performed by an individual to meet needs of daily living in many aspects of life including physical, psychological, social, spiritual, intellectual, and roles. Examples may include, but are not limited to, measures that address a patient's ability to perform activities of daily living (e.g. bathing, toileting, dressing, eating) or instrumental activities of daily living (e.g., medication management, shopping, food preparation).

**Functional Status** - A patient's ability to perform activities of daily living (e.g., bathing, toileting, dressing, eating) or instrumental activities of daily living (e.g., medication management, shopping, food preparation) due to musculoskeletal conditions.

**GI** -Gastrointestinal (GI) may include, but is not limited to, cirrhosis, gallbladder disease, GI bleeding, gastroenteritis, gastro-esophageal reflux disease (GERD)/peptic ulcer, and polyps.

**Group/Practice** -Two or more healthcare clinicians/providers who practice together, either at a single geographic location or at multiple locations.

**GU/GYN** -Genitourinary (GU)/Gynecologic (GYN) may include, but is not limited to, male and female reproduction and incontinence.

**Harmonization** - Having multiple similar measures can make it difficult to choose one to use. *Harmonization* is the process of editing the design of similar measures to ensure they are compatible. Measure developers can make changes to the way a topic or population is defined. Harmonization helps reduce the confusion of having measures that are similar but different.

**Competing measures** - address the same topic and the same population.

**Related measures** - address either the same topic or the same population.

**Health Information Technology (HIT)** - HIT is of increasing importance for healthcare. Using HIT means that computer hardware and software are doing the work of storing, retrieving, sharing, and analyzing healthcare data. HIT helps healthcare providers to communicate securely, coordinate care, and better manage services for their patients. HIT can include the use of electronic health records (EHRs) as well as personal health records (PHRs).

**Health IT Advisory Committee (HITAC)** - The Health IT Advisory Committee (HITAC) provides ongoing guidance to NQF's HIT portfolio and offers specific expertise on HIT projects, including specification of testing requirements for eMeasures and maintenance of the quality data set. HITAC is a standing committee of the Board of Directors and was created in December 2009.

**Health Information Technology Expert Panel (HITEP)** - An Agency for Healthcare Research and Quality-funded panel convened by NQF.

**Health Information Technology Standards Panel (HITSP)** -A cooperative partnership between the public and private sectors, formed in 2005 for the purposes of harmonizing and integrating standards that will meet clinical and business needs for sharing information among organizations and systems.

**Healthcare Associated Infections** -Infections that patients acquire during the course of receiving treatment for other conditions.

**Healthcare Provider Survey (Data Source)** -Data derived from surveys (computerized, pencil-and-paper, verbal, etc.) of healthcare clinicians/providers.

**Healthcare setting** - any facility or office, including a discrete unit of care within such facility, that is organized, maintained, and operated for the diagnosis, prevention, treatment, rehabilitation, convalescence or other care



of human illness or injury, physical or mental, including care during and after pregnancy. Healthcare settings include, but are not limited to, hospitals, nursing homes, rehabilitation centers, medical centers, office-based practices, outpatient dialysis centers, reproductive health centers, independent clinical laboratories, hospices, ambulatory surgical centers, and pharmacies. The boundary of a healthcare setting (the “grounds”) is the physical area immediately adjacent to the setting’s main buildings. It does not include nonmedical businesses such as shops and restaurants located close to the setting.

**Health Plan** -An organization that acts as an insurer for an enrolled population.

**HEENT** -Head, Eyes, Ears, Nose, and Throat (HEENT) may include, but is not limited to, dental, ear infection, hearing, pharyngitis, and vision.

**HL7 (Health Level 7)** -A standards-developing organization that provides standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery, and evaluation of health services.

**High-impact condition** - When a condition affects a large group of people, is expensive to treat, or has a large and long-lasting impact on a person’s well-being, it is a high-impact condition. NQF has developed two lists of high-impact conditions and health risks, one for children and another for people with Medicare.

**High quality data** –HITEP criteria for high quality data includes a) data are captured from an authoritative/accurate source; 2) data are coded using recognized data standards; c) method of capturing data electronically fits the workflow of the authoritative source; d) data are available in EHRs; and e) data are auditable.

**Home Health (Care Setting)** -Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services that are provided to a patient in his/her home or place of residence.

**Hospice (Care Setting)** -Palliative services provided to terminally ill patients and their families/caregivers in the patient's place of residence or in an inpatient facility.

**Hospital/Acute Care Facility (Care Setting)** -Setting in which healthcare services, including but not limited to, diagnostic, therapeutic, medical, surgical, obstetric, and nursing are provided, by or under the supervision of physicians, to patients admitted for a variety of health conditions.

**HVBP - Hospital Value-Based Purchasing** - a program implemented by CMS to update payment policies and payment rates for hospitals beginning in October 2012.

**Imaging/Diagnostic Study (Data)** -Data derived from an imaging/diagnostic study.

**Imaging Facility (Care Setting)** - Setting with the equipment to produce various types of radiologic and electromagnetic images and the necessary healthcare staff to interpret the images obtained.

**Infectious Diseases** - Infectious diseases may include, but are not limited to, hepatitis, respiratory infections, tuberculosis, and sexually transmitted infections.

**Informed consent** - a process of shared decision-making in which discussion between a person who would receive a treatment, including surgery or invasive procedure, and the caregiver/professional person who explains the treatment, provides information about possible benefits, risks and alternatives, and answers questions that result in the person's authorization or agreement to undergo a specific medical intervention. Documentation of this discussion should result in an accurate and meaningful entry in the patient record, which could include a signed "consent form." Signing a consent form does not constitute informed consent; it provides a record of the discussion.

**Infrastructure Supports** - Community and system capacity, health information technology, and workforce development. Examples may include, but are not limited to, measures that address the physical buildings of hospitals, clinics, and office components; the informational capabilities comprising paper records, electronic data, voice, and visuals; and the participating physicians, nurses, and support staff.

**Inpatient** - a patient admitted to a hospital or other facility

**IRF** - Inpatient Rehabilitation Facility

**Integrated Delivery System** -A healthcare entity that may include a variety of facilities and/or services including, but not limited to, hospitals, medical groups, skilled nursing facilities, home health, and/or insurance vehicles. This includes delivery systems that assume responsibility across settings for the complete patient-focused episode of care, such as accountable care organizations.

**Laboratory (Care Setting)** - Setting certified to test or evaluate specimens for clinical and/or diagnostic results.

**Laboratory (data)** -Data derived from a laboratory.

**Last Updated Date** - The date that the measure was last reviewed and updated.

**Level of Analysis** - Level(s) at which measurement is assessed.

**LTCH**- Long-Term Care Hospital

**Management Data** - Data derived within an organization's management systems such as facility census, staffing ratios or payroll.

**Maternal Care** - Women during preconception, pregnancy, childbirth and/or the postpartum period.

**Measure** - A healthcare performance measure is a way to calculate whether and how often the healthcare system does what it should. Measures are based on scientific evidence about processes, outcomes, perceptions, or systems that relate to high-quality care. NQF-endorsed measures are tools that show whether the standards for prevention, screening, and managing health conditions are being met.

**Structural measures** -Structural measures assess healthcare infrastructure.

**Process measures** - Process measures assess steps that should be followed to provide good care.

**Outcome measures** -Outcome measures assess the results of healthcare that are experienced by patients. They include endpoints like well-being, ability to perform daily activities, or even death. An

intermediate outcome measure assesses a factor or short-term result that contributes to an ultimate outcome, such as having an appropriate cholesterol level. Over time, low cholesterol helps protect against heart disease.

**Patient engagement and patient experience measures** - Patient engagement and patient experience measures use direct feedback from patients and their caregivers about the experience of receiving care. The information is usually collected through surveys.

**Composite measures** - Composite measures combine multiple measures to produce a single score. The information can be greater than the sum of its parts because it paints a more complete picture.

#### **MAP - Measure Application Partnership -**

The federal government and others who run healthcare programs are often considering new measures for their public reporting and performance-based payment programs. MAP is a large group of stakeholders that reviews those measures and makes recommendations about how they should be used. MAP also works to improve the consistency of measures being used in public- and private-sector programs.

**MU - Meaningful Use** - The American Recovery and Reinvestment Act authorizes the Centers for Medicare & Medicaid Services (CMS) to provide a reimbursement incentive for physician and hospital providers who are successful in becoming “meaningful users” of an electronic health record (EHR). These incentive payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the “meaningful use” definition, or they will be subject to financial penalties under Medicare.

**Measure Description** - A brief text description of the measure that includes the type of score, measure focus, target population, or time.

**Measure Developer** - Measure developers are individuals or organizations that design and build measures. Many people think that NQF develops measures but we do not.

**Measure, EHR** - An EHR measure is a healthcare quality measure specified for use with electronic health records; it is composed of data elements from the quality data set (see below), including code lists and measure logic, and can be translated to computer-readable specifications.

**Measure, quality** (also quality performance measure) - Numeric quantification of healthcare quality for a designated healthcare provider, such as hospital, health plan, nursing home, clinician, etc.

**Measure Endorsement Maintenance** - Every three years, endorsed measures in a topical area, as well as newly submitted measures, will undergo the nine-step consensus development process, including review against updated NQF evaluation criteria. In addition to ensuring currency of specifications, endorsement maintenance provides the opportunity to harmonize specifications and to ensure that an endorsed measure represents the “best in class.”

**Measure Evaluation Criteria** - NQF uses standard criteria to evaluate a measure and decide if it should be recommended for endorsement.

**Importance to measure and report** -This principle asks if there is evidence that measuring this topic will improve healthcare quality. The goal of this principle is to keep the focus on the most important areas for quality improvement. As the saying goes, “Not everything that can be counted counts.” There must also be scientific evidence to support the topic being measured and a significant opportunity to improve achievement.

**Scientific acceptability of the measurement properties** -This principle asks if a measure will provide consistent and credible information about the quality of care by evaluating its reliability and validity.

RELIABILITY reflects the amount of error in a measure and how well it distinguishes differences in performance. An unreliable measure doesn't function well across users or over time.

VALIDITY asks if a measure truly provides the information that it claims to. A measure that isn't valid is mistakenly evaluating something besides the topic of the measure. Such a measure will not lead to sound conclusions about the quality of care provided.

**Feasibility** -This criterion makes sure that the information needed to calculate a measure is readily available so that the effort of measurement is worth it. The most feasible measures use electronic data that is routinely collected during the delivery of care.

**Use and Usability** -This criterion checks that users of a measure—employers, patients, providers, hospitals, and health plans—will be able to understand the measure's results and find them useful for quality improvement and decision-making. It asks if the measure is strong enough to be used for various types of measurement programs, including public reporting, whether it leads to actual improvement for patients, and whether the benefits of the measure outweigh any potential harms.

**Measure score** - The numeric result that is computed by applying the measure specifications and scoring algorithm. The computed measure score represents an aggregation of all the appropriate patient-level data (e.g., proportion of patients who died, average lab value attained) for the entity being measured (e.g., hospital, health plan, home health agency, clinician, etc.). The measure specifications designate the entity that is being measured and to whom the measure score applies.

**Measure specifications** - Measure specifications are the technical instructions for how to build and calculate a measure. They describe a measure's building blocks: numerator, denominator, exclusions, target population, how results might be split to show differences across groups (stratification scheme), risk adjustment methodology, how results are calculated (calculation algorithm), sampling methodology, data source, level of analysis, how data are attributed to providers and/or hospitals (attribution model), and care setting.

Taken together, measure specifications are a blueprint that tells the user how to properly implement the measure within their organization.

**Measure Steward** - An individual or organization that owns a measure is responsible for maintaining the measure. Measure stewards are often the same as measure developers, but not always. Measure stewards are also an ongoing point of contact for people interested in a given measure.

**Measure testing** Empirical analysis to demonstrate the reliability and validity of the measure as specified including analysis of issues that pose threats to the validity of conclusions about quality of care such as

exclusions, risk adjustment/stratification for outcome and resource use measures, methods to identify differences in performance, and comparability of data sources/methods.

**Measure Type** - A domain of measurement such as process, outcome or patient experience with care.

**Measure Under Review** - There are four different types of review a measure could be under-going: ad hoc review, annual update review, time-limited review or endorsement maintenance.

**Medical device** - an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory, which is recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them; intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals; or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes.

**Medication error** - any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

**Medication Safety** - Any process or event surrounding medication use that may cause or lead to patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Examples may include, but are not limited to, measures that address prescribing, order communication, product labeling, and medication administration.

**Mental Health** - Mental health may include, but is not limited to, depression, serious mental illness, suicide, substance (alcohol and other drugs) use/abuse, and domestic violence.

**Misclassification** – an invalid reporting of performance

**Multi-Stakeholder Input** - NQF brings together different subject matter experts and organizations that want to improve healthcare quality. Because these groups include both government and private sector representatives, they are considered *public-private partnerships*. Balancing different groups' perspectives in an open and honest dialogue is core to our work. NQF brings together many multi-stakeholder groups to build consensus.

**Musculoskeletal** - Musculoskeletal may include, but is not limited to, osteoarthritis, rheumatoid arthritis, hip/pelvic fracture, joint surgery, low back pain, osteoporosis, and functional status related to musculoskeletal conditions.

**National** (e.g., Level of Analysis: Population) - A group of individuals within a single national entity (e.g., United States).

**National Priorities Partnership (NPP)** -

NPP is a partnership of 52 major national organizations with a shared vision to achieve better health, and a safe, equitable, and value-driven healthcare system. NPP was an early advocate for the creation of the National Quality Strategy (NQS) as a blueprint for achieving a high-value healthcare system. NPP continues to provide direction on healthcare policy and helps organizations pursuing the NQS to achieve quality improvement by making connections and helping to share information about innovative approaches.

**National Quality Strategy (NQS)** – The NQS is a nationwide effort to provide direction for improving the quality of health and healthcare in the United States. It is guided by three aims: better care, healthy people and communities, and affordable care.

**Neurology** - Neurology may include, but is not limited to, dementia, delirium, stroke and transient ischemic attack (TIA).

**NQF Endorsement** - NQF endorsement, which involves a rigorous, evidence-based review and a formal Consensus Development Process, has become the "gold standard" for healthcare performance measures.

**NQF Number** - A unique number is assigned to a measure once it is submitted to NQF.

**Numerator Statement** -A brief text description of what is being measured within the target population.

**Nursing Home/Skilled Nursing Facility** -Setting in which healthcare services are provided under medical supervision and continuous nursing care for patients who do not require the degree of care and treatment which a hospital provides and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board.

**Outcome (Measure Type)** -The health state of a patient (or change in health status) resulting from healthcare—desirable or adverse.

**Overuse (Cross-Cutting Area)** - where the “the potential for harm exceeds the possible benefits of care”. Examples may include, but are not limited to, measures that address inappropriate and excessive care (tests, drugs, procedures and visits), preventable emergency department visits and hospitalizations, and harmful preventive services with no benefit.

**Paired Measures** -Two or more individual measures that are endorsed for use together as a unit of measures but results in individual scores.

**Palliative Care and End-of-Life Care** -Appropriate and compassionate care for patients with serious, advanced illnesses. Examples may include, but are not limited to, measures that address the evaluation and effective management of physical symptoms (e.g., pain, shortness of breath, nausea) and psychological, social, and spiritual needs; effective communication, and access to palliative and hospice care services.

**Paper Records (Data Source)** -Data derived from manual abstraction from a medical record.

**Patient and Family Engagement (Cross-Cutting Area)** - Engaging patients and families in managing and evaluating their health and healthcare, and in making decisions about their care. Examples may include, but are not limited to, measures that address if patients are asked for feedback on their experience with care, have

access to tools and support systems enabling them to navigate and manage their care, and have access to information, and assistance that enables them to make informed decisions.

**Patient Engagement/Experience (Measure Type)** - The use of feedback from patients and their families/caregivers about their experience and/or engagement in decision making around care (e.g., CAHPS, other patient surveys).

**Patient Reported Data/Survey (Data Source)** -Data derived from surveys (computerized, pencil-and-paper, verbal, etc.) of patients and/or caregivers.

**Patient-reported outcomes and measurement** - Patients are a great source of information on health outcomes. Who better to answer questions such as, "Did you understand your doctor's instructions?" or "Can you walk several steps without pain?" NQF is working to increase the use of patient-generated information as part of performance measurement.

**PATIENT-REPORTED OUTCOME (PRO):** information about the patient, as communicated by that person

**PRO MEASURE (PROM):** an instrument, scale, or single-item measure that gathers the information directly from the patient

**PRO-BASED PERFORMANCE MEASURE (PRO-PM):** a way to aggregate the information that has been shared by the patient and collected into a reliable, valid measure of health system performance.

**Payment Program** -Intended for use in payment programs (e.g. P4P, shared savings programs, etc.)

**Peer groups**—the ways in which [resource use] measures ensure providers and health plans are compared to similar providers and health plans.

**Per capita measure**—counts all services provided to a person within a specific population, regardless of condition or encounters with system.

**Per episode measure**—counts resources based on bundles of services that are part of a distinctive event provided by one or multiple entities (e.g., health services provided associated with an event or series of events for acute myocardial infarction).

**Perinatal** - Perinatal may include, but is not limited to, conditions affecting women and/or fetuses/newborns during pregnancy, childbirth, newborn and post-partum periods as well as during the pre-pregnancy period.

**Pharmacy (Care Setting)** -Setting where medications and other medically related items and services are sold, dispensed or otherwise provided directly to patients.

**Pharmacy (Data)** -Data derived from a pharmacy.

**PQRS -Physician Quality Reporting System** - A voluntary reporting program implemented by CMS. The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries

**Population** (Level of Analysis) - A group of individuals defined by geography.

**Population Health** -Improving the health of the population through the delivery of effective preventive services, the promotion of healthy lifestyle behaviors, the use of community indices of health, and the assessment of environmental factors. Examples may include, but are not limited to, measures that address whether communities foster health and wellness as well as reflect national, state, and local systems of care that are reliable and effective in the prevention of disease, injury, and disability.

**Post-Acute/Long-Term Care Facility** -A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided in the community or in various types of facilities, including but not limited to nursing homes, skilled nursing facilities, rehabilitation facilities, and assisted living facilities.

**Prevention** -Prevention may include, but is not limited to, wellness, child development, immunization, malnutrition, obesity, physical activity, tobacco use and health screening.

**Process** (measure type) - A healthcare service provided to, or on behalf of, a patient. This may include, but is not limited to, measures that may address adherence to recommendations for clinical practice based on evidence or consensus.

**Professional Certification or Recognition Program** -Intended for use in professional certification or recognition programs.

**Public Reporting** - Making comparative performance results about identifiable, accountable entities freely available (or at nominal cost) to the public at large (generally on a public website).

**Public Health/Disease Surveillance** - Intended for public health and disease surveillance.

**Pulmonary/Critical Care** - Pulmonary/critical care may include, but is not limited to, asthma, chronic obstructive pulmonary disease (COPD), dyspnea, and pneumonia.

**Purpose/Use** -The purpose(s)/use(s) for which the measure is intended.

**Quality** - Quality is how good something is. For healthcare, it is often expressed in a range. When a person receives high-quality healthcare, he or she has received the right services, at the right time, and in the right way to achieve the best possible health.

**Quality construct** - A hypothetical concept of quality.

**Quality Data Model (QDM)** The QDM is part of NQF's work in health information technology. It is an "information model" that defines concepts used in quality measures and clinical care so that users can clearly and concisely locate and communicate pieces of electronic information.

The QDM can be used to help the designers of electronic health records to improve consistency between different systems. This improves automation and the ability of different systems to exchange electronic information..



**Quality Improvement** *Quality improvement (QI)* encompasses all of the work people are doing to improve healthcare and the health of individuals and populations. QI is both systematic and ongoing. Healthcare professionals and providers, consumers, researchers, employers, health plans, suppliers and other stakeholders all contribute to effective quality improvement.

*Clinical quality improvement* is a type of QI specifically designed to raise the standards for preventing, diagnosing, and treating poor health. **Quality Improvement with Benchmarking (external benchmarking to multiple organizations)** -Intended for quality improvement with external benchmarking.

**Quality of care** - a measure of performance on the six Institute of Medicine (IOM) specified healthcare aims: safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness.

**Quality Positioning System (QPS)** - The Quality Positioning System (QPS) is a web-based tool developed by NQF to help people more easily select and use NQF-endorsed® measures. You can search QPS for many helpful details about endorsed measures.

**QPS Portfolio**- A portfolio is a customized collection of NQF-endorsed measures selected by a QPS user. Some users have created portfolios of measures about specific topics or programs and published them in the system for others to view and use.

**Random error** – errors that are not systematic and create “noise” in the measure results.

**Rationale** – Succinct statement of the need for the measure. Usually includes statements pertaining to Importance criterion: impact, gap in care and evidence.

**Regional** -A group of individuals within a geographical area that exists within or across one or more states (e.g., Northeast, QIO).

**Registry (data)** - Data derived from a registry.

**Regulatory and Accreditation Programs** - Intended for use in regulatory and accreditation programs.

**Rehabilitation** -Setting in which long-term, comprehensive rehabilitation services are provided to patients for the alleviation or amelioration of the disabling effects of illness. These services are provided by various health professionals including, but not limited to, nurses and physical, occupational, and speech therapists.

**Related measures** – Measures that have either 1) the same target population being measured but a different concept for the measure focus (process, condition, event, outcome) OR the same concept for the measure focus (process, condition, event, outcome) and a different target population being measured

**Reliability** –the repeatability or precision of measurement. Reliability of data elements refers to repeatability and reproducibility of the data elements for the same population in the same time period. Reliability of the measure score refers to the proportion of variation in the performance scores due to systematic differences across the measured entities (signal) in relation to random variation or noise.

**Reliability testing** -Empirical analysis of the measure as specified that demonstrate repeatability and reproducibility of the data elements in the same population in the same time period and/or the precision of the computed measure scores. Reliability testing focuses on random error in measurement and generally involves

testing the agreement between repeated measurements of data elements (often referred to as inter-rater or inter-observer, which also applies to abstractors and coders) or the amount of error associated with the computed measure scores (signal vs. noise).

**Reliability, threats** -Some aspects of the measure specifications or the specific topic of measurement can affect reliability. Ambiguous measure specifications can result in unreliable measures. Small case volume or sample size, or rare events can affect the precision (reliability) of the measure score.**Renal** -Renal may include, but is not limited to, chronic kidney disease (CKD) and end stage renal disease (ESRD).

**Reserve Status** - Highly credible, reliable, and valid measures that have high levels of performance due to quality improvement actions. The purpose of reserve status is to retain endorsement of reliable and valid quality performance measures that have overall high levels of performance with little variability so that performance could be monitored in the future if necessary to ensure that performance does not decline.

**Resource use measures** - comparable measures of actual dollars or standardized units of resources applied to the care given to a specific population or event—such as a specific diagnosis, procedure, or type of medical encounter.

**Resource use service categories**—categories of resource units or services provided care for a patient or population. Resource units are generally identified through claims data and grouped into categories with similar types of claims (e.g., x-rays grouped into imaging category). Categories are generally measured in terms of dollars, but also can include resources not captured on a claim (e.g., nursing hours).

**Risk Adjustment** - The method of adjusting for clinical severity and conditions present at the start of care that can influence patient outcomes for making valid comparisons of outcome measures across providers. A corrective approach designed to reduce any negative or positive consequences associated with caring for patients of higher or lower health risk or propensity to require health services.

**Risk factors** – patient-related attributes or characteristics that contribute to outcomes

**Safety** -The reduction and mitigation of unsafe acts within the healthcare system. Examples may include, but are not limited to, measures that address reduction in healthcare-associated infections, serious adverse events, readmissions, and mortality rates.

**Selection** Use of performance results to make or affirm choices regarding providers of healthcare or health plans (e.g., an individual choosing a surgeon; an employer choosing a health plan to offer; a health plan choosing specialists to empanel; a family doctor choosing an oncologist to refer a cancer patient; an employee or Medicaid enrollee choosing a health plan during open enrollment).

**Serious Reportable Events (SRE)** – Despite the doctor’s vow to “first do no harm,” medical errors injure or kill thousands of patients each year. NQF has defined a list of serious reportable events (SREs) that cause or could cause significant patient harm. They include preventable events such as giving medication to the wrong person, failing to follow up on critical test results, operating on the wrong side of a patient’s body, or operating on the wrong patient altogether.

**Never events** - This informal term is often used in place of *serious reportable event*. Eliminating harm completely is important but difficult to do. Because of this, NQF uses *serious reportable event* instead of *never event*.

**Safe practices** - Part of NQF's work in promoting patient safety includes recommending this set of actions to improve patient safety. Hand hygiene, teamwork training, and informed consent are all examples of safe practices.

**Severity levels**—pre-determined levels of acuity used to rank and assign patients based on an assessment of the aggregate of their conditions/diagnosis codes.

**Standardized pricing**—pre-established uniform price for a service, typically based on historical price, replacement cost, or an analysis of completion in the market; removes variation in resource costs due to differences in negotiated prices or geographic differences based on labor or other input costs.

**Stratification**—division of a population or resource services into distinct, independent strata, or groups of similar data, enabling analysis of the specific subgroups. This type of adjustment can be used to show where disparities exist or where there is a need to expose differences in results.

**Structure** (as a measure type) -Features of a healthcare organization or clinician relevant to the capacity to provide healthcare. This may include, but is not limited to, measures that address health IT infrastructure, provider capacity, systems, and other healthcare infrastructure supports.

**Structured rules** - Widely accepted clinical recommendations expressed as coded logic statements made freely available via the Internet, developed by the AHRQ funded Structuring Care Recommendations for CDS project. These statements, or eRecommendations, will be structured in a standard fashion and use standard codes to identify patients for whom the recommendation applies and the actions that should be taken. Such logic statements can then be further adapted by clinical information system suppliers and care providers to generate automated reminders for specific clinicians and/or patients within deployed systems.

**Surgery** -Surgery may include, but is not limited to, general surgery, perioperative, thoracic, cardiac and vascular.

**System Capacity** -The physical capacity, workflow and throughput of facilities. Examples may include, but are not limited to, measures that address the presence or number of certain types of rooms or beds at a facility and the length of time between arrival and departure from the emergency department.

**Target Population** -The population intended to be measured.

**Taxonomy** - Generally, a model with hierarchy and classification assembled with a descriptive purpose.

**Team** -Two or more healthcare clinicians/providers, at one location or across different settings, who collaborate together for the care of a single patient or multiple patients.

**Time-limited endorsement** - Under rare circumstances, a measure can receive time-limited endorsement for up to a year. In addition to meeting the NQF the Measure Evaluation Criteria, a measure with time-limited endorsement must relate to a topic not addressed by an endorsed measure; meet a critical timeline for

implementing an endorsed measure (e.g., legislative mandate); not be complex (e.g., requiring risk adjustment or a composite); and, have testing completed within the 12 month time-limited endorsement period.

**Transparency** - Extent to which performance results about identifiable, accountable entities are disclosed and available outside of the organizations or practices whose performance is measured. The degrees of transparency are described in Table 2 and range from making performance results available only to a few selected staff within an organization to reporting the results to the public at large. The capability to verify the performance results adds significantly to measure transparency.

**Validation** - Process (testing) to determine if a measure has the property of validity. The term validation is often used in reference to the data elements and is another term for validity testing of data elements. Validation also is used in reference to statistical risk models where model performance metrics are compared between two different samples of data called the development and validation samples.

**Validity** - Validity refers to the correctness of measurement. Validity of data elements refers to the correctness of the data elements as compared to an authoritative source. Validity of the measure score refers to the correctness of conclusions about quality that can be made based on the measure scores (i.e., a higher score on a quality measure reflects higher quality).

**Validity testing** - Empirical analysis of the measure as specified that demonstrates that data are correct and/or conclusions about quality of care based on the computed measure score are correct. Validity testing focuses on systematic errors and bias. It involves testing agreement between the data elements obtained when implementing the measure as specified and data from another source of known accuracy. Validity of computed measure scores involves testing hypotheses of relationships between the computed measure scores as specified and other known measures of quality or conceptually related aspects of quality. A variety of approaches can provide some evidence for validity. The specific terms and definitions used for validity may vary by discipline, including face, content, construct, criterion, concurrent, predictive, convergent, or discriminant validity. Therefore, the proposed conceptual relationship and test should be described. The hypotheses and statistical analyses often are based on various correlations between measures or differences between groups known to vary in quality.

**Validity, threats** - In addition to unreliability, some aspects of measure specifications and data can affect the validity of conclusions about quality. Potential threats include patients excluded from measurement; differences in patient mix for outcome and resource use measures; measure scores generated with multiple data sources/methods; and systematic missing or “incorrect” data (unintentional or intentional).

**Value of care** - a measure of a specified stakeholder’s (such as an individual patient’s, consumer organization’s, payor’s, provider’s, government’s, or society’s) preference-weighted assessment of a particular combination of quality and cost of care performance.

**Value set** -A set or collection of concepts from one or more vocabulary code systems and grouped together for a specific purpose. A value set is a uniquely identifiable set of valid concept representations. A value set may be a simple flat list of concept codes drawn from a single code system, or it might be constituted by expressions drawn from multiple code systems (a code system is a system consisting of designations and meanings, for example LOINC, SNOMED-CT, ICD-10, or ISO 639 Language Codes).

**Venous Thromboembolism** -The prophylaxis of two related conditions: deep vein thrombosis (DVT) and pulmonary embolism (PE).

**Workforce** - All disciplines of healthcare professionals as well as others working in healthcare facilities. Examples may include, but are not limited to, measures that address the composition and characteristics of the workforce, staffing and skill mix, accreditation/certification, and workforce satisfaction surveys.