The National Quality Forum
National Annual Policy Conference 2006
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ABSTRACT

PURPOSE: The National Quality Forum's (NQF's) 7th Annual National Policy Conference on Quality provided a setting in which all healthcare quality stakeholders involved in implementing NQF-endorsed ™ national voluntary consensus standards could share information and discuss the rapidly evolving healthcare quality landscape.

SCOPE: More than 350 individuals representing a variety of healthcare stakeholders attended the conference. In addition to plenary sessions and other presentations, the meeting included six panel discussion sessions that focused on issues ranging from the rapidly evolving healthcare quality landscape to current national initiatives. During the conference, stakeholders from all areas of healthcare shared their perspectives on system-level issues as well as specific priority areas.

METHODS: The format of the conference included a mix of plenary sessions, panel discussions, council meetings, and a meeting of the NQF Board of Directors.

RESULTS: Participant evaluation and feedback were positive. We continue to review the content and structure of the meeting and make changes where appropriate to respond to the needs of our members. Attendees left the meeting with practical and constructive ideas for implementing NQF-endorsed voluntary consensus standards.

KEY WORDS: National Quality Forum, Annual Policy Conference, Healthcare Quality

PURPOSE

The National Quality Forum's (NQF's) 7th Annual National Policy Conference on Quality provided a setting in which all healthcare quality stakeholders involved in implementing NQF-endorsed ™ national voluntary consensus standards could share information and discuss the rapidly evolving healthcare quality landscape.

Janet M. Corrigan, PhD, NQF Chief Executive Officer, opened the conference by highlighting NQF progress and achievements and outlining plans for NQF in 2007. The conference featured plenary sessions and speakers as well as six panel discussions:

- Panel I: National Goals for Healthcare Quality Improvement. This panel focused on the Agency for Healthcare Research and Quality and its work in alignment with the Bush Administration's value-based healthcare initiative.

- Panel II: National Quality Alliances: Next Steps. This panel discussion included an overview of the AQA alliance and its mission as well as the Hospital Quality Alliance (HQA).

- Panel III: New Approaches to Aligning Payment with Quality. This panel included a discussion of pay-for-performance programs and the role of quality measures within them.

- Panel IV: Measuring Clinical Performance: The Devil Is in the Details. This panel included a discussion of the American College of Surgeon's National Surgical Quality Improvement Program.

- Panel V: Framework for Accountability. The focus of this panel was on the role of board certification in holding physicians accountable.

- Panel VI: Patient Safety and Quality. This panel discussed the Institute of Healthcare Improvement's 100,000 Lives Campaign.

SCOPE

NQF is a not-for-profit, open-membership, public benefit corporation. Its mission is to increase the delivery of high-quality healthcare by promoting a national strategy for healthcare quality measurement and reporting, including setting national healthcare quality goals; standardizing the means by which healthcare quality data are measured and reported; providing a consistent platform for data reporting and collection; and promoting the public disclosure of healthcare quality data.

NQF's 7th Annual National Policy Conference on Quality was held October 12-13, 2006, at the Grand Hyatt in Washington, DC. The conference focused on the rapidly evolving healthcare quality landscape.

NQF's member organizations represent the total spectrum of healthcare stakeholders and are categorized within four NQF Member Councils (Consumer; Purchaser; Health Professional, Provider, and Health Plan; and Research and Quality Improvement). The members work collaboratively to promote a common approach to measuring healthcare quality, including the endorsement and implementation of voluntary consensus standards. (See appendix B for a list of NQF Members.)

More than 350 individuals representing a variety of healthcare stakeholders from the public and private sector attended the conference. (See appendix C for the conference agenda.)

METHODS

As in past years, the conference included a mix of four types of meetings:

- Plenary sessions, which present an overview of topics related to quality measurement and improvement;
- Concurrent Inter-Council Sessions;
- Panel discussions, which focus on specific issues that impact healthcare quality; and
- Meeting of the NQF Board of Directors.

RESULTS

October 12, 2006 – Opening Remarks
Janet M. Corrigan, PhD, MBA
President and Chief Executive Officer, NQF

Dr. Corrigan opened the conference by highlighting the achievements of NQF since its inception, including the many robust sets of consensus standards that have been endorsed. Recently, NQF merged with the National Committee for Quality Health Care, introducing a new chapter for the organization. Dr. Corrigan discussed the strategic planning that has taken place since the merger, which has included:

- revising NQF's current mission and strategic goals;
- reconfiguring NQF's Member Councils and their respective roles; and
- amending NQF's Consensus Development Process (CDP).

Dr. Corrigan concluded by outlining the plans for NQF in 2007, which include:

- establishing national goals for public reporting;
- continuing the endorsement of national voluntary consensus standards;
- focusing on education and information dissemination; and
- participating in quality alliances.

October 12, 2006: Opening Plenary Session

Mark McClellan, MD, PhD, Administrator of the Centers for Medicare and Medicaid Services (CMS) spoke about the quality initiatives that occurred during his tenure. He also looked ahead to the future work the agency will be doing.

Dr. McClellan cited the agency's work with the provider alliances (i.e., the Quality Alliance Steering Committee, the AQA, and the HQA in implementing quality improvement initiatives). In addition, he noted that more provider alliances are under development (home health, End Stage Renal Disease) or are developing measures (i.e., the nursing home alliance). NQF plays a key role, because the alliances and CMS are committed to using NQF-endorsed™ standards.

Work also is occurring to introduce pay for performance at the federal level and in widespread competitive bidding projects. CMS has collaborated with Premier to establish a pay-for-performance program, and work is ongoing for a physician demonstration project that increases payment if there are measurable outcome improvements. These initiatives supplement the work done in the private sector by organizations such as the Leapfrog Group and pilot programs in multiple care settings.

Dr. McClellan discussed several additional projects CMS is pursuing, which include developing measures that can be used across sites of care, developing the next scope of work for the Quality Improvement Organizations (QIOs), and increasing support for local collaboratives, which are implementing measures. He also noted the opportunity for field testing new measures as they are developed (e.g., outcomes, patient satisfaction, episode based).

October 12, 2006 – Panel I: National Goals for Healthcare Quality Improvement
Participants: Carolyn Clancy, MD, Elliot Fisher, MD, MPH
Moderator: Janet Corrigan, PhD, MBA

Carolyn Clancy, MD, Administrator of the Agency for Healthcare Research and Quality (AHRQ), spoke about how the agency's work fits with the Bush Administration's value-based healthcare initiative.

She described the administration's initiative on reforming the healthcare system by making quality and price data available to individuals, which would allow them to comparison shop based on value. The cornerstones of this value-based health care system are quality standards, price standards, incentives, and interoperability. Quality standards depend on AHRQ's research, such as the *National Healthcare Quality Report* and the *National Healthcare Disparities Report*.

To illustrate the amount of work that needs to be done, Dr. Clancy noted that, in the Institute of Medicine's report *Crossing the Quality Chasm:* A New Health System for the 21st Century, AHRQ was asked to find priority areas in which making an improvement would be relatively easy. The criteria the agency used to identify the areas were impact, inclusiveness, and improvability. For diabetes, the following interventions were studied:

Patient education
Patient reminders
Promotion of self-management
Provider education
Provider reminders
Facilitated relay of clinical data
Audit and feedback
Organizational change
Financial, regulatory, legislative incentives

When AHRQ researchers looked at care coordination for seven different conditions, researchers found 53 systematic reviews of 17 different interventions and four conceptual frameworks. Dr. Clancy also noted that there are several challenges involved in measuring efficiency, cost, and quality.

Elliott Fisher, MD, MPH, from Dartmouth Medical School, spoke about efficiency in the healthcare system. He noted that national data show that healthcare costs doubled from 1996 to 2000. Based on his research, Dr. Fisher presented two conclusions that could be drawn:

- Higher spending across regions and physician groups is largely due to overuse of supply-sensitive services—such as hospital and intensive care unit stays, physician visits, and specialist consults.

- Overuse is largely a consequence of differences in clinical judgment (not outright errors) that arise in response to local organizational attributes (e.g., capacity, clinical culture) and state/national policies promoting growth and additional care.

Dr. Fisher stated that, to improve efficiency in the healthcare system, it is critical that institutions establish organizational accountability in an effort to increase quality and lower costs. He believes that future measurement initiatives should focus on the following:

- disease burden and outcomes;
- integration and coordination;
- informed patient choice; and
- longitudinal resource use.

Dr. Fisher concluded that improving efficiency will require fostering local organizational accountability for the longitudinal costs and quality of care. In addition, performance measurement, public reporting, payment reform, and technical assistance should be aligned toward improving efficiency.

October 12, 2006 – Panel II: National Quality Alliances: Next Steps
Participants: Karen Ignagni, Charles N. Kahn, III
Moderator: Joel Allison

Ms. Ignagni, representing the AQA, provided an overview of the group, which was established in 2004. Its mission is to improve quality and safety through collaboration and through:

- measuring performance at the physician or group level;
- collecting and aggregating data in the least burdensome way; and
- reporting meaningful information to consumers, physicians, and other stakeholders.

To date, AQA has successfully developed a framework for selecting measures. In addition, it has developed primary care measures, cardiology measures, cardiac surgery measures, and guidelines for developing efficiency measures. Future initiatives consist of exploring measures in specialty areas and standardized implementation rules for efficiency. Additionally, as a part of resolving challenges in the quality arena, AQA will work to map a national system in which data are aggregated and presented in a way that meets the needs of consumers and purchasers. AQA will continue to collaborate with HQA while seeking input from NQF to address the gaps in performance measurement.

Mr. Kahn, representing the HQA, provided an overview of the organization and described some of the work it contracted to Booz Allen Hamilton. HQA began in 2002 with the goal of bringing all hospital stakeholders together to provide guidance on national hospital quality initiatives. Currently, HQA is working to:

- develop a single reporting platform;
- recommend CMS hospital clinical measures; and
- address efficiency and pricing.

HQA is addressing several strategic planning issues at this time, including its

- role in the context of national quality reporting;
- governance (i.e., creating rules of engagement);
- operations: improving current ad hoc structure;
- quality measure infrastructure: implications of Booz Allen Hamilton analysis; and
- short- and long-term financing.

Mr. Kahn briefly discussed the objectives of a cost model project to be conducted by Booz Allen Hamilton. The study will examine the future resources necessary for quality reporting; electronic health records' impact on data collection; potential efficiencies in the quality reporting process; primary funding options; and gathering background from a cross-section of key stakeholders. HQA and AQA will collaborate in an effort to identify best practices, harmonize measures and standards, and establish new quality initiatives.

October 12, 2006 – Panel III: New Approaches to Aligning Payment with Quality
Participants: Alice Gosfield, Esq.
Moderator: Jeffrey Rich, MD

Ms. Gosfield spoke about the shortcomings of pay-for-performance programs and the myriad measures that are involved. She also discussed the PROMETHEUS payment system and how it can better align payment with quality.

There are several health quality initiatives, such as The Joint Commission ORYX program, the Hospital Quality Initiative conducted by Premier and CMS, and NQF's Consensus Development Process. Although many of the measures in these initiatives are used in pay-for-performance programs, many questions remain, such as "where is the money coming from?" "Are we getting what we want with information that comes from self-reporting or claims data?"

The PROMETHEUS provider payment system is an alternative to current payment systems. The purposes of PROMETHEUS are to:

- get beyond pay for performance, which is not sustainable as a payment reform model;
- deal with the shortcomings of fee for service (FFS) and capitation;
- reduce administrative burden to physicians and plans; and
- pay to deliver the right combination of services according to science**.**

In the PROMETHEUS system, the majority of the payment is made prospectively and is derived from an assessment of projected resources to deliver care within clinical practice guidelines. The negotiated base payment takes into account the severity and complexity of the patient's condition. The evidence-based case rate encompasses all providers treating a patient for that condition and is allocated among them in accordance with that portion of the care they negotiate to deliver.

The comprehensive scorecard is risk adjusted and measures process, outcomes, and patient experience of care. There is a performance contingency holdback of 10 percent on chronic care and 20 percent on acute care. This provides the basis to pay the remainder of the rate in accordance with scores. Better-performing providers will get better margins and potentially additional money. The system is voluntary, and negotiated FFS as well as capitation would remain in place for other conditions.

Providers can configure their groupings however they wish. Single hospitals can bid, and competitors can bid together as well (e.g., multiple oncology groups in a market). The bidding entity does not have to be a legal entity.

October 12, 2006 – Lunchtime Speaker

Alex Azar II, the Deputy Secretary for the U.S. Department of Health and Human Services, was the lunchtime speaker at the NQF National Policy Conference. He spoke about how President Bush's value-based healthcare initiative will address the current problems in the healthcare system.

While Deputy Secretary Azar said he believed that our healthcare system provides the best care in the world, quality care is not correlated with price. He noted three primary obstacles to building a better healthcare system.

- The U.S. healthcare system is price blind, meaning that the cost is not a factor in healthcare decision making;
- It is silent regarding quality—information is not available on the quality of care for a particular procedure, at any given facility; and
- The incentives currently are in the wrong place.

The Deputy Secretary observed that one of the outcomes of the employer-based healthcare system is that consumers do not have any information on the quality of care they are receiving.

He noted that change is critical because the current financing system is unsustainable. President Bush's plan is designed to decrease spending, improve quality, and make the healthcare market more transparent. The executive order issued by President Bush directs federal agencies to:

- Prioritize the adoption and interoperability of electronic health records.
- Increase cost transparency.
- Provide information on the quality and efficiency of healthcare.

October 12, 2006 – Panel IV: Measuring Clinical Performance: The Devil Is in the Details
Participants: Darrell Campbell, MD, Karen Kmetik, PhD, Jeffrey Rich, MD, Linda Stierle, RN
Moderator: Reva Winkler, MD

Dr. Campbell described the American College of Surgeon's National Surgical Quality Improvement Program (NSQIP). The goal of NSQIP is to establish a standardized reporting infrastructure to monitor and improve the quality of surgical care. NSQIP uses

- prospective data;
- standardized definitions;
- trained nurse reviewers;
- defined endpoints (e.g., 30-day mortality and 30-day morbidity);
- inter-rater reliability; and
- risk adjustment.

There are currently 125 hospitals, including some that are in the Veterans Affairs (VA) health system, that are enrolled in NSQIP. Since the introduction of NSQIP into VA hospitals, there has been a 45 percent reduction in morbidity.

Dr. Kmetik spoke about the Physician Consortium for Performance Improvement (PCPI) and its process for endorsing measures.

PCPI is convened and staffed by the American Medical Association. Its membership includes groups throughout medicine, including medical boards and specialties, CMS, AHRQ, the National Committee for Quality Assurance (NCQA), The Joint Commission, and others.

PCPI's vision is to become the leading source for evidence-based clinical performance measures and outcome reporting tools for physicians. Their process for developing measures is one that involves consortium work groups that draft measures that are then revised based on public comments and reviewed and approved by the full consortium. The group tests and reviews the measures and revises them based on the results and sends them to NQF for endorsement and the AQA for selection.

On average, PCPI receives about 130 comments during each public comment period. Several kinds of groups respond during the public comment periods, including health plans, specialty societies, group practices, private practitioners, hospitals, and academic health centers. Dr. Kmetik noted that initially PCPI's process took 16 months from beginning to end. Currently, the entire process takes 4 months. As of October 6, 2006, PCPI's portfolio of measures includes:

- 20 measurement sets;
- 115 individual measures;
- 69 measures in development; and
- 26 NQF-endorsed™ Consortium measures.

Dr. Rich spoke about the Virginia Cardiac Surgery Initiative (VCSQI), a voluntary, self-funded consortium of hospitals and surgeons throughout the state that came together to improve quality and contain costs. Its mission is to:

- improve the quality of cardiac surgical care on a statewide basis;
- contain healthcare costs through application of a unique database and the development of cost-savings models; and
- test reimbursement methodologies that reward quality improvement.

The quality goals of VCSQI are:

- to demonstrate that collaboration between hospitals and physicians can improve clinical quality across an entire state in programs of all sizes through the sharing of data, outcomes analysis, and process improvement; and
- implement continuous quality improvement through the use of the Society of Thoracic Surgeons (STS) Database.

VCSQI adopted the clinical standards in the STS National Cardiac Database, because it provides a common language and standards. In addition, STS developed risk-adjusted mortality and morbidity algorithms to provide benchmark measures. Data are collected, managed, and sent to the STS data warehouse semi-annually by the physician practice or by the hospital.

For financial information, VCSQI adopted the standards in the UB-92 MEDPAR national database, which is charge based. It contains 239 revenue codes for cardiac surgery. VCSQI created an additional 21 categories and used the Medicare cost-to-charge ratio to produce normalized charges.

Currently, the database has over 30,000 records and allows users to drill down into details by hospital, diagnosis-related group, patient selection criteria, and surgeon. One of the statistics Dr. Rich noted was that, with a 16.2 percent incidence of atrial fibrillation in CABG patients, a reduction to 10 percent (i.e., best practice) saves $1,279,666 over 2 years in Virginia. Applied nationally using the STS database and quality improvement processes, $80,000,000 in savings would result by addressing just atrial fibrillation.

Ms. Stierle spoke about the American Nurses Association's (ANA) National Database of Nursing Quality Indicators (NDNQI), which is a repository for nursing-sensitive indicators. The NDNQI is the only database containing data collected at the nursing-unit level. The database is maintained by the University of Kansas School of Nursing. Currently, it is being used in 1,015 hospitals nationwide.

Before a hospital can participate in the database, staff need to be trained on how to collect the data. All reports to NDNQI are anonymous. ANA provides quarterly reports to participants comparing them to institutions of similar size. The database contains the following NQF-endorsed ™ measures:

- Patient Falls
- Patient Falls with Injury
    - Injury Level
- Nursing Hours per Patient Day
    - Registered Nurses (RN) Hours per Patient Day
    - Licensed Practical/Vocational Nurses (LPN/LVN) Hours per Patient Day
    - Unlicensed Assistive (UAP) Hours per Patient Day

- Staff Mix
    - % of Nursing Hours Supplied by RNs
    - % of Nursing Hours Supplied by LPN/LVNs
    - % of Nursing Hours Supplied by UAPs
    - % of Nursing Hours Supplied by Agency Staff
- Practice Environment Scale (PES)

October 12, 2006 – Panel V: Framework for Accountability
Participants: F. Daniel Duffy, MD, Peter Lee, JD, Margaret O'Kane, John Rother, JD
Moderator: Gerald Shea

Dr. Duffy spoke about the role of board certification in holding physicians accountable. While focusing on the details of the internal medicine board certification, he noted that the board certification processes for all medical specialties have similar characteristics.

Dr. Duffy noted that 10 years is the half-life of medical knowledge. Consequently, a one-time certification process is not acceptable.
After an individual receives a medical degree and completes an accredited residency program, he or she obtains a medical license and goes through the certification process. During the certification process, the individual is evaluated through observed practice and oral examination, which tests clinical judgment and medical knowledge. Internal medicine has a 10-year re-certification cycle. Individuals undergo a self-evaluation every 1 to 2 years. There also is an examination between year 6 and 10.

Continuing medical education is an important tool in the recertification process. One tool that is available to internal medicine physicians is the Practice Improvement Module (PIM). The results from a patient survey, chart review, and practice survey are combined into a report, which helps identify measures for improvement.

Mr. Lee provided an overview of a framework for accountability that would be useful for health plans. The goal of the framework is to examine what the plan is doing and hold it accountable. Mr. Lee notes that plans should be contracted with only if they are accredited by NCQA. Health plans should be differentially compensated based on the quality of care received by consumers. There should be continual discussion of performance between purchasers and plans. Additionally, health plans should actively participate in national collaborations.

Ms. O'Kane spoke about the need for healthcare quality measures to be linked back to an accountable clinical entity. She noted several improvements in healthcare quality, including the following:

- Children today are nearly three times as likely to have had all recommended immunizations as in 1997.
- Diabetics today are twice as likely to have cholesterol controlled (<130 mg/dL) as in 1998.
- More than 96 percent of cardiac patients are prescribed beta-blockers after a heart attack (up from 62 percent in 1997).

However, she noted several areas where improvement is still needed:

- Lack of evidence (e.g., effective treatment for esophageal cancer, breast cancer, efficacy of physical therapy in back pain, appropriate care for patients with multiple conditions).
- Failure to develop consensus across specialties (e.g., when to perform surgery for back pain, orthopedics versus neurosurgery versus internists).
- Unusable guidelines (e.g., screening for depression or cholesterol levels in the general population).
- Data availability (e.g., little documentation, sample sizes often limited/insufficient).
- Expense of data collection (e.g., measures relying on chart review).
- Warring measures (e.g., resource use/cost measures).
- Political opposition (e.g., measures of appropriateness).
- Unclear accountabilities (e.g., responsibility for at-risk patients after discharge).

Potential accountable clinical entities were illustrated (e.g., coordinated group practices, hospital-centered networks, and health plans).

Mr. Rother spoke about how the consumer's perspective of accountability is changing. Previously consumers assumed that by choosing a "good" physician they did not need to be as concerned about external factors that may affect their health. However, it is becoming clear that a "good" physician in a "bad" system may result in poor-quality care. In addition, it is becoming clear that accountability should not be equated with the ability to receive monetary compensation when errors occur.

Consumers now want outcome data representing all aspects of care. They want to know where the high-performing physicians are located. Data must be presented in a consumer-friendly format. Providers also need to continue to participate in quality improvement programs. Mr. Rother concluded that NQF's role in promoting patient friendly measures, developing best practices for consumer education, and raising consumer awareness is crucial.

October 12, 2006 – Panel VI: Patient Safety and Quality
Participants: Donald M. Berwick, MD, MPP, KBE
Moderator: William Roper, MD, MPH

Dr. Berwick spoke about the Institute for Healthcare Improvement's 100,000 Lives Campaign. The objective of the campaign was to save 100,000 lives in the United States through error prevention and quality improvement. The campaign established six activities that would reduce patient mortality in the hospital. The activities were:

- deployment of rapid response teams;
- delivery of reliable, evidence-based care for acute myocardial infarction;
- medication reconciliation;
- prevention of central line infections;
- prevention of surgical site infections; and
- prevention of ventilator-associated pneumonias.

The campaign received significant stakeholder support throughout the country, with 3,103 hospitals enrolled in the campaign. Several of the participating hospitals greatly reduced the number of infections and experienced lower mortality rates during the 18-month campaign. Dr. Berwick stated that research indicates that 122,342 lives were saved as a result of the 100,000 Lives Campaign.

John M. Eisenberg Patient Safety and Quality Award Presentation

The National Quality Forum and The Joint Commission awarded the 2006 John M. Eisenberg Patient Safety and Quality Awards. The honorees, by award category, were as follows:

Individual Achievement: Donald Berwick, MD, MPP, KBE. Dr. Berwick is president, CEO, and cofounder of the Institute for Healthcare Improvement in Boston. Dr. Berwick has published extensively in professional journals in the areas of healthcare policy, decision analysis, technology assessment, and healthcare quality management. Dr. Berwick has received numerous awards and honors for his work, including the 1999 Ernest A. Codman Award and, in 2001, the first Alfred I. DuPont Award for excellence in children's healthcare from Nemours, one of the nation's largest pediatric healthcare provider organizations. In 2002, he was given the "Award of Honor" from the American Hospital Association for outstanding leadership in improving healthcare quality.

In 2004, he was inducted as a Fellow of the Royal College of Physicians in London. In 2005, in recognition of his exemplary work for the National Health Service in the UK, he was appointed honorary Knight Commander of the Most Excellent Order of the British Empire—the highest award given to non-British citizens.

Research: Jerry H. Gurwitz, MD. Dr. Gurwitz is a nationally recognized expert in geriatric medicine and in the use of drug therapy in the elderly. He holds the Dr. John Meyers Endowed Chair in Primary Care Medicine at the University of Massachusetts Medical School, where he is Chief of the Division of Geriatric Medicine and Professor of Medicine and Family Medicine/Community Health. He also serves as the Executive Director of the Meyers Primary Care Institute. He has been the recipient of the William B. Abrams Award in Geriatric Clinical Pharmacology from the American Society for Clinical Pharmacology and Therapeutics and the George F. Archambault Award from the American Society of Consultant Pharmacists. Dr. Gurwitz's most recent research efforts relate to developing and testing interventions to reduce the risk of medication errors that lead to adverse drug events in the elderly.

Innovation in Patient Safety and Quality at a Regional Level: Minnesota Alliance for Patient Safety (MAPS). The Alliance was established in 2000 as a partnership among the Minnesota Hospital Association, the Minnesota Medical Association, the Minnesota Department of Health, and more than 50 other public-private healthcare organizations working together to improve patient safety. MAPS has been a forum for sharing best practices and fostering commitment to patient safety improvement efforts.

Innovation in Patient Safety and Quality at a Regional Level: Pennsylvania Patient Safety Authority. The Patient Safety Authority is an independent state agency established and charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in hospitals, ambulatory surgical facilities, birthing centers, and other facilities.

Innovation in Patient Safety and Quality at a Local Level: Wichita City-wide Collaborative. Thirty-five institutions developed multidisciplinary teams in November 2003 to meet the common goal of providing quality care in their community. This effort put decision makers together and empowered them to improve patient care. The work has provided valuable lessons and opportunities for sharing in-depth knowledge and for demonstrating that patient safety and quality improvement goals can be achieved by working together.

October 13, 2006 - Member Council Meetings

Each member organization of NQF belongs to one of four Member Councils: Consumer, Purchaser, Health Professional, Provider and Health Plan, and Research and Quality Improvement. Sessions were primarily business and content meetings that focused on NQF projects and NQF strategic planning.

October 13, 2006 - Board of Directors Meeting

Dr. Corrigan began the meeting by noting that copies of her report had been made available (see appendix A). Then she provided the following project updates.

National Framework and Preferred Practices for Palliative and Hospital Care
Following the Board's endorsement at the May 17, 2006, meeting, the requisite appeals period was announced. No appeals were registered, so the report is in the publishing phase and is anticipated in late October or early November 2006.

National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism (VTE)
On May 17, 2006, the Board endorsed the framework, key characteristics of practices, and two performance measures that had been approved by all four Councils. One appeal was received and will be considered at the meeting on October 13.

For the additional 10 candidate measure identified as suitable for further beta testing, preliminary specifications were developed by NQF's partner in this project, The Joint Commission, and reviewed by the TAP. The specifications were sent to 20 volunteer beta test sites and, based on results from this testing, eight measures were recommended for pilot testing. The Joint Commission then sought approximately 55 volunteer hospitals with a variety of characteristics to ensure a representative sample of hospitals to assist it in gaining an early base of experience in implementing the VTE measures. Hospitals will be randomly selected based on the hospital characteristics (e.g., bed size, geographic location, case volume) by November 3, 2006.

VTE Summit
One March 24, 2006, NQF convened an invitational summit to identify a patient-centered national action plan for VTE prevention, treatment, and research. More than 100 research, clinician, and consumer leaders participated in the day-long intensive working summit to identify content and plan action steps for consumer messaging and placement, clinical action, research gaps, and opportunities relevant for VTE care. The document is now in the publishing phase.

Cancer Care Quality Measures

The National Cancer Institute concluded its additional work with the American College of Surgeons on pilot testing a select group of colorectal and breast cancer measures, which resulted in several additional potential accountability measures. The Steering Committee will meet in October to consider the revised specifications.

Member voting for the "Symptom Management/End-of-life Care" draft report concluded on September 29, 2006; preliminary results indicate that all items have passed. The Board will consider these results at the meeting on October 13.

Institute for Quality Laboratory Management

As follow up to the laboratory medicine workshop held on January 11, 2006, NQF has commissioned a paper to review an existing, targeted set of laboratory medicine quality measures and to discuss proposed implementation strategies from the laboratory's perspective. The paper is being finalized and discussions are being held with CDC on follow-up activities related to the paper.

National Voluntary Consensus Standards for Hospital Care—Additional Priority Areas, 2005

No appeals were received for the three-item care transition measure endorsed by the Board at its May meeting, so the document was published in July 2006. As noted previously, CMS has asked NQF to consider its 30-day pneumonia mortality measure, which had been withdrawn during consideration of other pneumonia mortality measures under this project (none were recommended). The project's Technical Advisory Panel and Steering Committee will review this measure against the others originally identified and make a recommendation on whether it should advance to the review and voting phases of the CDP.

Ambulatory Care Quality

The final report for Phase 3, Cycle 1, consensus standards was completed and made available on the NQF website in electronic format only; the specifications have been available in electronic format since clearing the appeals period. Phase 3, Cycle 1, of the project encompassed measures for the following priority areas: asthma, coordination of care, hypertension, medication management, obesity, and prevention. The Board endorsed the measures and recommendations that had been approved by all four Councils on the first ballot. No appeals were received, and the report is now in the publication process; the specifications have been available on the website since the Board's action.

Phase 3, Cycle 2, included the following priority areas: diabetes, heart disease, prenatal, behavioral/substance use disorders, and bone care. The Steering Committee met July 25-26, 2006, and its recommendations were forwarded for Member and public review, which closes on October 13, 2006.

As previously reported, RWJF identified the two additional priorities it wished NQF to address in the ambulatory care project: healthcare disparities and efficiency. The Healthcare Disparities TAP has met several times by conference call and will meet in person on November 28, 2006. As mutually agreed to between NQF and RWJF, the priority area of efficiency will be addressed in the context of the goal-setting project.

Phase 3, Cycle 3, is underway and likely will include patient experience of care measures (although ACAHPS is on a separate, faster track); recommendations related to a disparities-sensitive set; and ambulatory surgical centers. Also included in this cycle will be areas funded by the new CMS contract: 1) eye care, 2) osteoporosis, 3) skin conditions, including skin cancer, 4) gastrointestinal diseases, including GERD, 5) geriatrics, and 6) emergency care.

The project's Implementation TAP will meet December 18-19, 2006, in conjunction with an Ambulatory Measurement and Reporting Implementation Conference.

Voluntary Consensus Standards for Adult Diabetes Care: 2005 Update
The stand-alone diabetes project has been integrated into the larger ambulatory project for Phase 3, Cycle 2. The 2005 update report and specifications were published in electronic format, only.

Standardizing a Measure of Patient Experience (HCAHPS)
The survey is anticipated to be implemented nationally in the latter part of 2006, with results reported to the public in late 2007.

Evidence-based Practices for Substance Use Disorders (SUD)
The SUD Steering Committee and TAP have met, and the Steering Committee will meet on October 18, 2006 for the second time. The focus of the meeting will be identifying recommended practices for Member and public review.

Voluntary Consensus Standards Maintenance Committees (CSMC)

Safe Practices for Better Healthcare
Voting on the recommended revisions to this 2003 report ended on September 29, 2006. Preliminary results indicate all practices and recommendations passed all four Member Councils and will be considered by the Board at the meeting on October 13.

Serious Reportable Adverse Events in Healthcare
Voting on the recommended revisions to this 2002 report ended on September 28, 2006. Preliminary results indicate all events and recommendations passed all four Member Councils and will be considered by the Board at the meeting on October 13.

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Evaluation of the Conference

The National Quality Forum employed a number of strategies to evaluate and document the participation, experience, and outcomes of the 2006 Annual Policy Conference. In addition to the meeting evaluation form, attendees were able to provide comments about each individual session. Attendees also identified the types of meeting activities that were the most helpful and the meeting activities that were missing. They also gave specific suggestions about what they would like to see in next year's meeting.

The conference was extremely well attended, and participants generally were satisfied with the plenary and panel discussions, because they provided high-level policy briefings on a number of timely and important issues.

Specific Comments

◊ Good job - high-quality programs. Would support a longer conference at least once year - 3 days not 2.5
◊ Any possibility of offering CME in the future? Also, two slides per page for the handouts are preferable to three slides per page (if possible)
◊ Someone to present their view of the direction of policy, quality, & whether quality groups, such as the NQF have been successful in their mission
◊ More user sessions - entities doing P4P public reporting. Extremely disappointed the call for abstracts limited applicants to those using NQF endorsed measures
◊ I think timing for notification of award winners was not timely. I found out about award one day prior to early bird registration fee increase.
◊ Post materials to the web site for members to access before the meeting.
◊ Superb meeting, fascinating - if anything not quite enough time for all speakers. However, the time was well used. The more parochial speakers w/political agendas were less impressive (esp. Ignani & Kahn).
◊ Nice perspective gathered from presentations. Some very good speakers Thursday.
◊ More specific information about measure selection & which types are likely to engage physicians & other clinicians
◊ Representing a healthcare provider, the accountability session was not helpful. I was looking for more "out of the box" information. Presentations often ran over time limit.
◊ The content/process balance was excellent, and needs to be maintained.

PRESIDENT'S REPORT
for the
NQF Board of Directors Meeting
October 13, 2006

A. Office Management. To accommodate staff growth due to the merger and new projects, NQF has leased an additional 1,900 square feet adjacent to current space (effective October 2006), and in July 2007 will acquire an additional 3,300 square feet.

B. Staff. Since the Board last met there have been four new hires: Cara Lesser joined NQF in July 2006 as Vice President, Executive Institute; Kristyne McGuinn joined NQF in August 2006 as a Research Analyst; Terri Smith Moore, PhD, RPh joined NQF as a Senior Program Director to lead the 'Therapeutic Drug Management' project; and Karen Adams, PhD, will join NQF in October 2006 as a Senior Program Director to lead the 'Priority-Setting' project.

With respect to departures: Kendra Shanley, Research Assistant, and Drew Himmelstein, Program Analyst/Meetings Assistant, left in September 2006 for graduate school; Carol Bock, Assistant to the President, left in August 2006 to relocate out-of-state; Phil Dunn, MSJ, Vice President, Communications and Public Affairs left in July 2006 to relocate out-of-state; and Melinda Murphy, RN, MS, CNA, Senior Vice President converted to a contractor in June 2006.

Currently we are recruiting for two Research Assistants/Research Analysts and preparing to interview candidates for the Assistant to the President/Executive Assistant position.

C. Membership. If all applications are approved at this meeting, NQF membership will be 341.

All Member Councils continue to meet regularly by conference calls.

D. Governance. The Governance Committee met twice to discuss options to reconfiguring the Consensus Development Process (CDP) (e.g., at-large voting, approval of consensus standards through a body other than the Board of Directors, and new mission and goals statements). The recommendations resulting from these deliberations will be discussed at the October Board meeting.

Jonathan Perlin, MD, PhD departed in August 2006 as Under Secretary for Health of the Veterans Health Administration (VHA), and Brig. Gen. Michael J. Kussman, MD, MS (U.S. Army Ret) has been appointed Acting Under Secretary for Health. Dr. Perlin and Dr. Kussman discussed the VHA seat and agreed to have Dr. Fred Grover continue as the VHA designee.

To accommodate potential realignment/reconfiguration of the Councils and Board of Directors, the Governance Committee will recommend against holding the scheduled leadership elections in Fall/Winter 2006 for the Research and Quality Improvement Council (chaired by Jeff Rich) and the Health Professional, Provider, and Health Plan Council (chaired by Jessie Sullivan). The Committee will recommend that current office holders (including Vice Chairs) continue into 2007 until the reconfiguration/realignment is settled.

E. Financial. In June 2006, NQF concluded two years of negotiations and finalized arrangements with Pfizer for a project to endorse a comprehensive national framework and set of voluntary consensus standards to evaluate, measure, and report a broad view of therapeutic drug management quality. Additionally, VHA has contributed funds and we anticipate United Healthcare will do so as well.

In August 2006, NQF and the Agency for Healthcare Research and Quality finalized the scope of work and concluded contract negotiations for the project on selected hospital measurement areas. This project originally was approved for expedited consensus by the Board in May 2004. The current project, which will not be under expedited consensus, will consider a narrower range of hospital areas, composite measures, and reporting options.

Also in August 2006, the Centers for Medicare and Medicaid Services (CMS) issued a $50,000 purchase order for NQF to consider CMS' 30-day pneumonia mortality measure, which had been withdrawn during consideration of other pneumonia mortality measures in the Additional Hospital Priority Areas, 2005 project. The previous Technical Advisory Panel and Steering Committee will review this measure against the others originally identified.

NQF concluded negotiations with CMS on a $1.5 million contract for federal fiscal year 2007 which involves consensus development projects related to measures for physician specialty services (both ambulatory and hospitals), ESRD, and home health care; some very preliminary funds also are provided to explore hospital emergency care.

The Commonwealth Fund has awarded NQF a $20,000 grant for the upcoming Ambulatory Measurement and Reporting Implementation Conference, to be held December 18-19, 2006, in Washington, DC. The meeting will be held in conjunction with the ambulatory project's Implementation Technical Advisory Panel.

F. NQF Strategic Repositioning.

Enhancing the Consensus Development Process

The Ad-hoc Committee on Enhancing the Consensus Development Process (Ad-hoc CDP Committee) met by conference call and in person. The Ad hoc Committee's preliminary recommendations will be considered by the Board at the October 13 meeting. The draft report addresses: measure submission guidelines; harmonization of measure specifications across care settings; NQF Committee composition; application of NQF's evaluation criteria for proposed consensus standards; periodic evaluation of the CDP and its outcomes; and national priority-setting for public reporting.

NQF Collaboration with the Alliances

NQF is a member of the AQA/HQA Steering Committee established in July 2006 by the Secretary of Health and Human Services. In addition, NQF has assumed the lead role in chairing and staffing a subgroup aimed at harmonizing measures in the AQA and HQA pipelines. NQF also is actively engaged in the various activities of the HQA and AQA.

G. Program Updates.

National Framework and Preferred Practices for Palliative and Hospital Care

Following the Board's endorsement at the May 17, 2006, meeting, the requisite appeals period was announced. No appeals were registered, so the report is in the publishing phase and is anticipated in late October or early November 2006.

National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism (VTE)

On May 17, 2006, the Board endorsed the framework, key characteristics of practices, and two performance measures that had been approved by all four Councils. One appeal was received and will be considered at the meeting on October 13.

For the additional 10 candidate measure identified as suitable for further beta testing, preliminary specifications were developed by NQF's partner in this project, JCAHO and reviewed by the TAP. The specifications were sent to 20 volunteer beta test sites and, based on results from this testing, eight measures were recommended for pilot testing.

The Joint Commission is now seeking approximately 55 volunteer hospitals with a variety of characteristics to ensure a representative sample of hospitals to assist it in gaining an early base of experience in implementing the VTE measures. Hospitals will be randomly selected based on the hospital characteristics (e.g., bed size, geographic location, case volume) by November 3, 2006.

VTE Summit

One March 24, 2006, NQF convened an invitational summit to identify a patient-centered national action plan for VTE prevention, treatment, and research. More than 100 research, clinician and consumer leaders participated in the day-long intensive working summit to identify content and plan action steps for consumer messaging and placement, clinical action, research gaps, and opportunities relevant for VTE care. The document is now in the publishing phase.

Cancer Care Quality Measures

The National Cancer Institute concluded its additional work with the American College of Surgeons on pilot testing a select group of colorectal and breast cancer measures, which resulted in several additional potential accountability measures. The Steering Committee will meet in October to consider the revised specifications.

Member voting for the "Symptom Management/End-of-life Care" draft report concluded on September 29, 2006; preliminary results indicate that all items have passed. The Board will consider these results at the meeting on October 13.

Institute for Quality Laboratory Management

As follow-up to the laboratory medicine workshop held on January 11, 2006, NQF has commissioned a paper to review an existing, targeted set of laboratory medicine quality measures and to discuss proposed implementation strategies from the laboratory's perspective. The paper is being finalized and discussions are being held with CDC on follow-up activities related to the paper.

National Voluntary Consensus Standards for Hospital Care—Additional Priority Areas, 2005

No appeals were received for the 3-item care transition measure endorsed by the Board at its May meeting, so the document was published in July 2006. As noted previously, CMS has asked NQF to consider its 30-day pneumonia mortality measure, which had been withdrawn during consideration of other pneumonia mortality measures under this project (none were recommended). The project's Technical Advisory Panel and Steering Committee will review this measure against the others originally identified and make a recommendation on whether it should advance to the review and voting phases of the CDP.

Ambulatory Care Quality

The final report for Phase 3, Cycle 1 consensus standards was completed and is available on the NQF web site in electronic format only; the specifications have been available in electronic format since clearing the appeals period. Phase 3, Cycle 1 of the project encompassed measures for the following priority areas: asthma, coordination of care, hypertension, medication management, obesity, and prevention. The Board endorsed the measures and recommendations that had been approved by all four Councils on the first ballot. No appeals were received, and the report is now in the publication process; the specifications have been available on the web site since the Board's action.

Phase 3, Cycle 2 included the following priority areas: diabetes, heart disease, prenatal, behavioral/substance use disorders, and bone care. The Steering Committee met July 25-26, 2006 and its recommendations were forwarded for Member and public review, which closes on October 13, 2006.

As previously reported, RWJF identified the two additional priorities it wished NQF to address in the ambulatory care project: healthcare disparities and efficiency. The Healthcare Disparities TAP has met several times by conference call and will meet in person on November 28, 2006. As mutually agreed to between NQF and RWJF, the priority area of efficiency will be addressed in the context of the Goal-setting project.

Phase 3, Cycle 3 is underway and likely will include patient experience of care measures (although ACAHPS is on a separate, faster track); recommendations related to a disparities-sensitive set; and ambulatory surgical centers. Also included in this Cycle will be areas funded by the new CMS contract: 1) eye care, 2) osteoporosis, 3) skin conditions, including skin cancer, 4) gastrointestinal diseases, including GERD, 5) geriatrics, and 6) emergency care.

The project's Implementation TAP will meet December 18-19, 2006, in conjunction with an Ambulatory Measurement and Reporting Implementation Conference.

Voluntary Consensus Standards for Adult Diabetes Care: 2005 Update

The stand-alone diabetes project has been integrated into the larger ambulatory project for Phase 3, Cycle 2. The 2005 update report and specifications were published in electronic format, only.

Standardizing a Measure of Patient Experience (HCAHPS©)

The survey is anticipated to be implemented nationally in the latter part of 2006, with results reported to the public in late 2007.

Evidence-based Practices for Substance Use Disorders (SUD)

The SUD Steering Committee and TAP have met, and the Steering Committee will meet on October 18, 2006 for the second time. The focus of the meeting will be identifying recommended practices for Member and public review.

Voluntary Consensus Standards Maintenance Committees (CSMC)

Safe Practices for Better Healthcare

Voting on the recommended revisions to this 2003 report ended on September 29, 2006. Preliminary results indicate all practices and recommendations passed all four Member Councils and will be considered by the Board at the meeting on October 13.

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Executive Institute (EI)

The National Advisory Committee, which oversees EI activities, met on July 13, 2006, to: review current EI activities, begin planning for future topics and products, identify short-term and long-term fundraising/sponsorship strategies, and receive an update on the Quality Award process.

Development of two CEO Survival Guides™ is underway: one on personal health records (PHR) and one on patient safety. The Task Force overseeing the PHR CEO Survival Guide met on July 18, 2006, and it is anticipated this guide will be available in late 2006/early 2007. The Task Force for the Patient Safety CEO Survival Guide met on September 11, 2006; this product is scheduled for release in March 2007.

Recognition Programs

The 2006 Eisenberg award recipients will be honored at the National Policy Conference/7th Annual Meeting on October 12, in Washington, DC. Presented jointly with JCAHO, the following awardees will be honored: Donald Berwick, MD, MPP (Individual); Jerry H. Gurwitz, MD (Research); Minnesota Alliance for Patient Safety and Pennsylvania Patient Safety Authority (Innovation, Regional); and Wichita Citywide Heart Care Collaborative (Innovation, Local).

The Blue Ribbon Review Panel for the National Quality Healthcare Award, appointed previously by NCQHC, met on June 16, 2006, and revised the application and award criteria. The application period is September 12, 2006, to November 21, 2006. A Call for Nominations for jurors to review the applications, forwarded to NQF Members in July, closed on August 25, 2006; juror appointments are pending. The award will be presented on March 8, 2007, at an awards gala dinner. The dinner will be preceded by an Executive Institute colloquium on the afternoon of March 8 and be followed by a Board meeting on March 9, 2007.

NATIONAL QUALITY FORUM

MEMBERS

AARP
Abbott Laboratories
ABIM Foundation
Abiomed
Academy of Managed Care Pharmacy
ACC/AHA Task Force on Performance Measures
Accreditation Association for Ambulatory Health Care - Institute for Quality Improvement
ACS/MIDAS+
Administrators for the Professions
Adventist HealthCare
Advocate Health Partners
Aetna
AFL-CIO
AGA Institute
Agency for Healthcare Research and Quality
Alegent Health
Alliance for Quality Nursing Home Care
America's Health Insurance Plans
American Academy of Family Physicians
American Academy of Hospice and Palliative Care Medicine
American Academy of Nursing
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association of Ambulatory Surgery Centers
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American Board of Medical Specialties
American Academy of Hospice and Palliative Medicine
American Clinical Laboratory Association
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Medical Quality
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology
American College of Surgeons
American Federation of Teachers Healthcare
American Geriatrics Society
American Health Quality Association
American Heart Association
American Hospice Foundation
American Hospital Association
American Managed Behavioral Healthcare Association
American Medical Association
American Medical Group Association
American Nurses Association
American Optometric Association
American Osteopathic Association
American Pharmacists Association Foundation
American Psychiatric Institute for Research and Education
American Society for Gastrointestinal Endoscopy
American Society for Quality - Health Care Division
American Society for Therapeutic Radiology and Oncology
American Society of Anesthesiologists
American Society of Clinical Oncology
American Society of Health-System Pharmacists
American Society of Hematology
American Society of Interventional Pain Physicians
American Society of Plastic Surgeons
AmSurg Corporation
Anesthesia Patient Safety Foundation
Ascension Health
Association for Professionals in Infection Control and Epidemiology
Association of American Medical Colleges
Association of Professors of Medicine
Astra Zeneca
Atlantic Health System
Aurora Health Care
AYR Consulting Group
Baptist Memorial Health Care
Battelle Memorial Institute
Baxter
Bayhealth Medical Center
Baylor Health Care System
Beverly Enterprises
BJC HealthCare
Blue Cross Blue Shield Association
Boca Raton Community Hospital
Bon Secours Health System
BoozAllenHamilton
Bristol Myers Squibb
Bronson Healthcare Group
Bronx Lebanon Hospital Center
Buyers Health Care Action Group
Calgary Health Region - Quality Improvement and Health Information
California HealthCare Foundation
Cancer Quality Council of Ontario
Cardinal Health
CareScience
Carolinas Medical Center
Catholic Health Association of the United States
Catholic Health Initiatives
Catholic Healthcare Partners
Cedars-Sinai Medical Center
Center to Advance Palliative Care
Centers for Disease Control and Prevention
Centers for Medicare and Medicaid Services
Central Baptist Hospital
Centura Health
Cerner Corporation
Chesapeake Bay ENT
Childbirth Connection
Children's Hospitals and Clinics of Minnesota
Child Health Corporation of America
CHRISTUS Health
CIGNA Healthcare
City of New York Department of Health and Hygiene
Clark Consulting-Healthcare Group
Cleveland Clinic Foundation
CNA Corporation
College of American Pathologists
Community Health Accreditation Program
Condell Health Network
Connecticut Hospital Association
Consumer Coalition for Quality Health Care
Consumers Advancing Patient Safety
Consumers' Checkbook
Coordinating Center
Coral Initiative
Council of Medical Specialty Societies
C.R. Bard.
CRG Medical
Delmarva Foundation
Detroit Medical Center
Dialog Medical
Disease Management Association of America
District of Columbia Department of Health
Duke University Health System
ECRI
eHealth Initiative
Eli Lilly and Company
Employer Health Care Alliance Cooperative (The Alliance)
Employers' Coalition on Health
Evanston Northwestern Healthcare
excelleRx
Exempla Healthcare
Exeter Health Resources
Federation of American Hospitals
First Health
Florida Health Care Coalition
Florida Hospital Medical Center
Florida Initiative for Children's Healthcare Quality
Ford Motor Company
Forum of End Stage Renal Disease Networks
General Motors
Gentiva Health Services
Glaxosmithkline
Good Samaritan Hospital
Greater Detroit Area Health Council
Greater New York Hospital Association
Hackensack University Medical Center
HCA
Health Alliance of Mid-America
Health Care Compliance Strategies
Health Grades
Health Information Management Systems Society
Health Management Associates
Health Plus
Health Resources and Services Administration
Health Services Advisory Group
HealthCare 21
Healthcare Leadership Council
HealthHelp
HealthPartners
HealthSouth Corporation
The Heart Center of Indiana
HIP Health Plans
Henry Ford Health System
Hoag Hospital
Horizon Blue Cross Blue Shield of New Jersey
Hospira
Hospital for Special Surgery
HRDI
HR Policy Association
Hudson Health Plan
Illinois Department of Public Health
Illinois Hospital Association
Infectious Diseases Society of America

NATIONAL QUALITY FORUM

MEMBERS

Infusion Nurses Society
Institute for Clinical Systems Improvement
Institute for Safe Medication Practices
Integrated Healthcare Association
Integrated Resources for the Middlesex Area
INTEGRIS Health
Intermountain Healthcare
International Association of Machinists
Iowa Foundation for Medical Care
Iowa Healthcare Collaborative
IPRO
Jefferson Health System, Office of Health Policy and Clinical Outcomes
John Muir/Mt. Diablo Health System
Johns Hopkins Health System
Johnson & Johnson Health System
Joint Commission on Accreditation of Healthcare Organizations
Kaiser Permanente
KPMG
KU Med at the University of Kansas Medical Center
Lake Forest Hospital
Leapfrog Group
Lehigh Valley Business Conference on Health
The Lewin Group
Long Term Care Institute
Los Angeles County - Department of Health Services
Loyola University Health System - Center for Clinical Effectiveness
Lumetra
Lutheran Medical Center
Maine Health Management Coalition
Maine Quality Forum
March of Dimes
Mayo Foundation
McKesson Corporation
MedAssets
Medical University of South Carolina
MedMined
MedQuest Associates
MedSphere
MedStar Health
Medstat
Memorial Health University Medical Center
Memorial Hermann Healthcare System
Memorial Sloan Kettering Cancer Center
Mercy Medical Center
Meridian Health System
The Methodist Hospital
Michigan Purchasers Health Alliance
Milliman Care Guidelines
Minnesota Community Measurement
Munson Medical Center
National Academy for State Health Policy
National Association for Healthcare Quality
National Association for Home Care & Hospice
National Association of Chain Drug Stores
National Association of Children's Hospitals and Related Institutions
National Association of Health Data Organizations
National Association of Public Hospitals and Health Systems
National Association of State Medicaid Directors
National Breast Cancer Coalition
National Business Coalition on Health
National Business Group on Health
National Citizen's Coalition for Nursing Home Reform
National Coalition for Cancer Survivorship
National Committee for Quality Assurance
National Committee for Quality Health Care
National Consensus Project on Quality Palliative Care
National Consortium of Breast Centers
National Consumers League
National Family Caregivers Association
National Hospice and Palliative Care Organization
National Institutes of Health
National Partnership for Women and Families
National Patient Safety Foundation
National Research Corporation
National Rural Health Association
Nebraska Heart Hospitals
Nemours Foundation
New Jersey Health Care Quality Institute
New York Presbyterian Hospital and Health System
Northwestern Memorial Corporation
North Carolina Baptist Hospital
North Carolina Center for Hospital Quality and Patient Safety
North Mississippi Medical Center
North Shore - Long Island Jewish Health System
North Texas Specialty Physicians
Northeast Health Care Quality Foundation
Norton Healthcare
Novant Health
NY University College of Nursing/John A. Hartford Institute
Oakwood Healthcare System
Ohio KePRO
OmniCare
Online Users for Computer-assisted Healthcare
Owens & Minor
Pacific Business Group on Health
PacifiCare
PacifiCare Behavioral Health
Palmetto Health Alliance
Park Nicollet Health Services
Partners HealthCare
Partnership for Prevention
Pennsylvania Health Care Cost Containment Council
Pennsylvania Patient Safety Authority
Pfizer
Pharmacy Quality Alliance
PhRMA
Physician Consortium for Performance Improvement
Planetree
Premier
Presbyterian Healthcare Services
Press, Ganey Associates
Providence Health System
Renal Physicians Association
Research!America
Rhode Island Department of Health
Robert Wood Johnson Health Network
Robert Wood Johnson Hospital - Hamilton
Robert Wood Johnson University Hospital - New Brunswick
Roswell Park Cancer Institute
sanofi-aventis
Schaller Anderson
Sentara Norfolk General Hospital
Service Employees Industrial Union
Sisters of Charity of Leavenworth Health System
Sisters of Mercy Health System
Society for Healthcare Epidemiology of America
Society of Critical Care Medicine
Society for Hospital Medicine
Society of Thoracic Surgeons
Sodexho Healthcare Services
Solucient
St. Louis Business Health Coalition
St. Mary's Hospital Medical Center
Stamford Health System
State Associations of Addiction Services
State of California - Office of the Patient Advocate
State of New Jersey Department of Health and Senior Services
State University of New York - College of Optometry
Substance Abuse and Mental Health Services Administration
Sutter Health
Tampa General Hospital
Tenet Healthcare
Texas Medical Institute of Technology
Thomas Jefferson University Hospital
Triad Hospitals
Trinity Health
UAB Health Systems
Uniform Data System for Medical Rehabilitation
United Hospital Fund
UnitedHealth Group
United Surgical Partners International
University Health Systems of Eastern Carolina
University Hospitals of Cleveland
University of California-Davis Medical Group
University of Michigan Hospitals and Health Centers
University of North Carolina - Program on Health Outcomes
University of Pennsylvania Health System
University of Texas-MD Anderson Cancer Center
URAC
US Department of Defense - Health Affairs
US Office of Personnel Management
US Pharmacopeia
UW Health
Vail Valley Medical Center
Value Options
Vanguard Health Management
Veterans Health Administration
VHA
Virginia Cardiac Surgeons Quality Initiative
Virtua Health
Vitas Healthcare Corporation
Washington State Health Care Authority
Waukesha Elmbrook Health Care
WellPoint
West Virginia Medical Institute
Wisconsin Collaborative for Healthcare Quality
Yale New Haven Health

THE NATIONAL QUALITY FORUM

NATIONAL POLICY CONFERENCE ON QUALITY

AGENDA

Thursday, October 12

8:00 am **Continental Breakfast** — Independence Foyer

8:30 am **Welcome and Opening Remarks** — Independence A
Janet M. Corrigan, PhD, MBA
National Quality Forum

8:45 am **Update on CMS Initiatives on Quality**
Moderator: Janet M. Corrigan, PhD, MBA, National Quality Forum

Mark B. McClellan, MD, PhD
Centers for Medicare & Medicaid Services

9:30 am **National Goals for Healthcare Quality Improvement**
Moderator: Janet M. Corrigan, PhD, MBA, National Quality Forum

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

Elliott S. Fisher, MD, MPH
Dartmouth Medical School

10:30 am **Break**

10:45 am **National Quality Alliances: Next Steps**
Moderator: Joel T. Allison, Baylor Health Care System

Karen Ignagni
America's Health Insurance Plans/AQA

Chip Kahn, III
Federation of American Hospitals/Hospital Quality Alliance

11:30 am **New Approaches to Aligning Payment with Quality**
Moderator: Jeffrey B. Rich, MD, Virginia Cardiac Surgery Initiative

Alice G. Gosfield, Esq.
Alice G. Gosfield & Associates

12:15 pm **Lunch** — Independence B/C/D/E

Alex M. Azar, II
US Department of Health and Human Services

1:15 pm **Measuring Clinical Performance: The Devil is in the Details**
Moderator: Reva Winkler, MD, National Quality Forum

Darrell A. Campbell, Jr., MD
Univ of Michigan Health System/Surgical Care Improvement Project

Karen Kmetik, PhD
Physician Consortium for Performance Improvement

Jeffrey B. Rich, MD
Virginia Cardiac Surgery Initiative

Linda J. Stierle, RN
American Nurses Association

Thursday, October 12 (continued)

2:30 pm **Break** — Independence Foyer

2:45 pm **Framework for Accountability** — Independence A
Moderator: Gerald Shea, AFL-CIO

F. Daniel Duffy, MD
American Board of Internal Medicine

Peter V. Lee, JD
Pacific Business Group on Health

Margaret E. O'Kane
National Committee for Quality Assurance

John C. Rother, JD
AARP

4:00 pm **Perspectives on Patient Safety and Quality**
Moderator: William L. Roper, MD, MPH, UNC Health Care System

Donald M. Berwick, MD, MPP, KBE
Institute for Healthcare Improvement

4:45 pm **Break**

5:00 pm **John M. Eisenberg Patient Safety and Quality Awards**
Janet M. Corrigan, PhD, MBA
National Quality Forum

Dennis S. O'Leary, MD
Joint Commission on Accreditation of Healthcare Organizations

Honorees:
Donald M. Berwick, MD, MPP, KBE
Jerry H. Gurwitz, MD
Minnesota Alliance for Patient Safety
Pennsylvania Patient Safety Authority
Wichita Citywide Heart Care Collaborative

5:30 pm **Reception** — Grand Café

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THE NATIONAL QUALITY FORUM

MEETING OF THE BOARD OF DIRECTORS

AGENDA

Friday, October 13

8:00 am	**Member Council Meetings/Continental Breakfast—NQF Members Only**	
	Consumer Council	Independence E
	Health Professional, Provider and Health Plan Council	Independence F/G/H
	Purchaser Council	Independence D
	Research and Quality Improvement Council	Independence B/C
10:00 am	**Welcome and Introductions—Open Session** William L. Roper, MD, MPH, Chair Janet M. Corrigan, PhD, MBA, President & CEO	Independence A
10:05 am	**ACTION: Minutes of the Meeting of the Board of Directors, May 17, 2006** William L. Roper, MD, MPH, Chair	
10:10 am	**ACTION: Review of Consensus Reports** Serious Reportable Events in Healthcare—Voting Results Safe Practices for Better Healthcare—Voting Results Symptom Management and End-of-Life Care in Cancer Patients—Voting Results Standardizing a Patient Safety Taxonomy—Follow-up National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism—Appeal	
11:00 am	**Priority and Goal-Setting Initiative: Update** Janet M. Corrigan, PhD, MBA, President & CEO	
11:10 am	**Ad Hoc Committee on the Consensus Development Process: Preliminary Report** George Isham, MD, MS and Cary Sennett, MD, PhD, Committee Co-Chairs	
12:15 pm	**Working Lunch—Executive Session**	
1:00 pm	**NQF Restructuring—Open Session** **Mission and Goals Statement** John D. Rother, JD, Chair, Governance Committee **CDP Approval Body** John D. Rother, JD, Chair, Governance Committee **Member Council Reconfiguration** Janet M. Corrigan, PhD, MBA, President & CEO Member Council Chairs and Vice Chairs	Independence A
3:00 pm	**New Program Highlights and Operational Updates** **National Quality Healthcare Award: New Emphasis** Cara Lesser, MPP, Vice President, Executive Institute **National Voluntary Consensus Standards for Hospital Care: Additional Priorities 2006-2007** Melinda L. Murphy, RN, MS, CNA, Clinical Consultant **New CMS Tasks** Reva Winkler, MD, MPH, Clinical Consultant **Therapeutic Drug Management** Terri Smith Moore, PhD, RPh, Senior Program Director	
3:30 pm	**Adjourn**	

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