The National Quality Forum
National Annual Policy Conference 2007
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ABSTRACT

PURPOSE: The National Quality Forum's (NQF's) 8th 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. Presentations and discussions focused on measuring quality, developing new payment and incentive systems, building public-private partnerships, and adopting innovations in clinical health system design, medical management, electronic health records, and nursing care.

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 and strategies 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) 8th 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, MBA, NQF Chief Executive Officer, opened the conference by highlighting NQF's achievements and outlining plans for 2008. The conference featured plenary sessions and speakers as well as four panel discussions:

Panel I: Community Partnerships to Drive Quality Improvement. This panel described the work occurring among various initiatives in implementing the Federal Government's value-based healthcare agenda.

Panel II: Medications and Quality: A National Perspective. This panel discussed the work being done to develop quality measures for medications and why it has become increasingly important.

Panel III: Moving Performance Measures into Electronic Health Record Requirements. This panel described the vital link between quality measures and electronic health records and how they can be used to improve patient care.

Panel IV: Technology Applications to Enhance Nursing Practice. This panel reviewed results from two studies designed to identify the types of technology and the necessary workflow changes that would support nursing practice.

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 8th Annual National Policy Conference on Quality was held September 26-27, 2007, at the Renaissance Washington Hotel 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 eight NQF Member Councils (Consumer; Health Plan; Health Professional; Provider; Public and Community Health Agency; Purchaser; Quality Measurement, Research and Improvement; Supplier and Industry). 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 three types of meetings:

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

RESULTS

September 26, 2007 – Opening Keynote Address
Arnold Milstein, MD, MPH
Pacific Business Group on Health

Arnold Milstein, MD, MPH, spoke about the challenge that is slowing the increased use of provider performance measures and why it is important for us to overcome this challenge. Everyone agrees that provider measures need to be widely used. The point of disagreement is on how developed the measures need to be before they are publicly available.

Dr. Milstein advocated moving quickly but judiciously in making provider ratings available to the public. It is important to move quickly because waiting will result in consumers spending months to find the right provider to address their health issues, which may be severe and disabling. However, it is also important to be judicious to ensure that measures are fair to providers. He noted that there will always be some degree of error in measures. However, research shows that consumers are willing to tolerate some degree of error, even when there is an increased risk of death or disability.

September 27, 2007 – Opening Remarks
Janet M. Corrigan, PhD, MBA
President and Chief Executive Officer, NQF

Janet Corrigan, PhD, MBA, NQF President and CEO, began by welcoming everyone and stating that the meeting would provide an excellent opportunity for a dialogue between NQF and its Members. She stated that the past year had been one of extraordinary change for NQF and that the meeting marked the end of NQF's initial strategic initiative under her leadership. Over the past year, NQF has accomplished several things, including:

- **New mission statement.** In the past year, NQF has adopted the following three part mission statement: NQF will work collaboratively with other stakeholders to improve the quality of American healthcare via (1) setting national priorities and goals for performance improvement; (2) endorsing national voluntary consensus standards for measuring and publicly reporting on performance; (3) promoting the attainment of national goals through education and outreach programs.

- **New governance and committee structure.** Over the past year, NQF has implemented a new governance and committee structure. The changes include:

    - **Board of Directors**: A new Board of Directors will meet for the first time this week.

    - **Directorate Committees**: NQF has inaugurated the National Priorities Partners and the Consensus Standards Approval Committee. The National Priorities Partners are charged with identifying national healthcare priorities and goals. The Consensus Standards Approval Committee will make final endorsement recommendations to the Board for all NQF Consensus Development projects.

    - **Member Councils**: NQF increased the number of member councils from 4 to 8. The new member councils are: Consumers; Purchasers; Health Professionals; Provider Organizations; Supplier and Industry; Health Plans; Public/Community Health Agencies; and Quality Measurement, Research, and Improvement.
      Dr. Corrigan recognized each of the Council Chairs and said that they would be the "voice" of Members within NQF.

The chairs will be expected to communicate their councils' concerns to the Consensus Standards Approval Committee during consensus development. Other duties will include working with NQF staff on council survey mechanisms to determine Member preferences regarding priorities, serving on a leadership network designed to focus leadership and broaden outreach, and assisting in the development of a survey to gauge NQF's performance as an organization. In addition, Dr. Corrigan noted that each council will have an NQF staff liaison to provide both guidance and to act as means of communication back to the organization

- **NQF's Project Portfolio:** Many domains of quality have been covered in the NQF portfolio over the past year. This year, NQF's completed projects have resulted in the endorsement of 222 national voluntary consensus standards, which include:

    - 160 acute care hospital performance measures, including 15 cross-cutting and 26 clinician-level, 59 condition-specific, and 2 patient-experience measures, as well as 30 safe practices and 28 serious reportable events;

    - 131 ambulatory care measures, including 10 asthma and respiratory care, 9 bone and joint disease, 9 diabetes, 12 emergency care, 4 eye care, 5 geriatric, 19 heart disease, 3 hypertension, 4 medication management, 12 mental health and substance abuse, 2 obesity, 9 patient experience, 4 prenatal, 18 prevention, and 11 substance use measures; and

    - 31 nursing and home health measures.

Moreover, NQF's current endeavors include three education and outreach programs as well as 16 consensus development projects in which performance measures, practices, or frameworks are being considered for endorsement.

Dr. Corrigan noted that NQF will face several challenges in the future, including

- The evolving pay-for-performance movement;
- Developing paired sets of process and outcome measures;
- Moving from paper to electronic resources; and
- Developing value and efficiency measures

September 27, 2007 – Medicare Performance Monitoring and Payment Initiatives: What to Expect in the Coming Year
Herb Kuhn

Herb Kuhn, from the Centers for Medicare and Medicaid Services (CMS), spoke about how Medicare's focus on "value-based purchasing" is helping to drive quality improvement. CMS defines value-based purchasing broadly, including a focus on prevention, pay for reporting, pay for performance, transparency, and cost-effectiveness.

One example of "value-based purchasing" that Mr. Kuhn noted was CMS's decision to stop paying for hospital-acquired infections. This decision was in part based on a Leapfrog Group study of 1,200 hospitals. The study found that 87 percent of the surveyed hospitals did not follow guidelines for infection prevention.

Mr. Kuhn stated that CMS found that using payment incentives has consistently improved care. One example he noted is the partnership between CMS and Premier, Inc., for the Hospital Quality Incentive Demonstration Project. The purpose of the demonstration project is to improve the quality of inpatient care for Medicare patients by increasing payments in several clinical areas, including heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Data from this demonstration project are available on the CMS website.

September 27, 2007 – Panel I: Community Partnerships to Drive Quality Improvement
Participants: Peter Lee, JD, Michael Painter JD, MD
Moderator: Christopher Queram, MA

Mr. Queram began by noting that the purpose of the Robert Wood Johnson Foundation's Aligning Forces for Quality (AF4Q) initiative and its Regional Quality strategy is to align regional quality coalitions. He then went on to describe the executive order that President Bush issued last year addressing healthcare quality.

The purpose of the executive order is to ensure that healthcare programs administered or sponsored by the federal government build on collaborative efforts to promote four cornerstones for healthcare improvement: adoption of standard measures of quality, adoption of standard measures of price, adoption of interoperable information technology, and rewards/incentives for superior value. These cornerstones have been applied through the following initiatives:

- Community Leaders for Value-Driven Healthcare: chartered by the Secretary of the U.S. Department of Health and Human Services (HHS), provides support to the Value-Driven Healthcare initiative

- Value Exchanges: These organizations are chartered by the Agency for Healthcare Research and Quality (AHRQ). The exchanges will use of information to effect behavior change, foster collaboration among multiple stakeholders, and create the opportunity to share "best practices."

- Better Quality Information for Medicare Beneficiaries: This program is run by CMS and works to aggregate data, test and calculate performance measures, provide feedback to providers, and publicly report information. The program provides financial support, access to Medicare data, and access to the National Learning Network to various initiatives. The six pilot sites include California Cooperative Healthcare Reporting Initiative, Indiana Health Information Exchange, Massachusetts Health Quality Partners, Minnesota Community Measurement, Arizona State University - Center for Health Information & Research, and the Wisconsin Collaborative for Healthcare Quality.

Mr. Queram stated that Mr. Lee would be addressing these initiatives during his presentation.

Michael Painter, JD, MPH, described the Robert Wood Johnson Foundation's AF4Q initiative and its Regional Quality Strategy. He also discussed the Quality Alliance Steering Committee (QASC). The goal of the AF4Q initiative is to help communities dramatically improve:

- Performance measurement and public reporting;
- Community quality improvement capacity; and
- Consumer engagement

The Robert Wood Johnson Foundation's Regional Quality Strategy will focus on

- Building on AF4Q
- Focusing on patient centered care across the continuum;
- Increasing attention to racial and ethnic disparities; and
- Ensuring that regional quality improvement includes nursing and nurse leadership

QASC was established in 2006 by several organizations, including the Hospital Quality Alliance and the AQA. Its members include provider groups, consumer groups, business alliances, payer groups, and regional collaborations. QASC's goal is to advance high quality, cost-effective, patient-centered healthcare by providing a national framework for implementing quality and cost measures to improve care around the country.

Specific elements of QASC's work include:

- National health plan data aggregation and newly constructed quality measures;
- New episode of care cost measures;
- Value Exchange chartering and pilot sites; and
- Racial and ethnic care disparities

Mr. Lee provided details about Community Leaders for Value-Driven Healthcare, Value Exchanges, and the Better Quality Information for Medicare Beneficiaries.

- Community Leaders for Value-Driven Healthcare: This program designated by the Secretary of HHS recognizes organizations working toward achieving the four cornerstones. As of September 4, 2007, 81 organizations have been selected.

- Value Exchanges: These organizations will be selected semi-annually by a multi-stakeholder committee overseen by AHRQ. The committee will ensure the selected organizations represent multiple stakeholders. The Vale Exchanges will seek to adopt and implement nationwide consensus-based and endorsed principles, standards, and measures within the community. In addition, they will provide performance results generated from Medicare data and have access to nationwide learning network.

- Better Quality Information for Medicare Beneficiaries: This program is funded by CMS and implemented through Quality Improvement Organizations which help Medicare beneficiaries. Currently, six communities across the country serve as pilot sites. The program works to advance physician performance measurement by:

    - Aggregating commercial, Medicare, and Medicaid administrative data;
    - Testing and calculating selected AQA adopted quality measures at the individual physician level;
    - Establishing a common physician attribution methodology;
    - Giving providers feedback about their performance based on the aggregation data; and
    - Testing additional measures and processes.

September 27, 2007 – Aetna's Innovative Payment Programs
Troyen Brennan, MD, JD, MPH

Troyen Brennan, MD, JD, MPH, spoke about the role private healthcare purchasers have in improving healthcare quality and provided an overview of Aetna's Aexcel program. He began by stating that that there is no doubt in the research community that there is a lot of variation in quality among physicians. In addition, while the government and the community are essential players in improving quality and reducing costs, the role of the private payer is just as critical. Private payers can improve quality and reduce costs through tiered programs that use incentives to move patients toward higher-quality physicians. One example is Aetna's Aexcel program, which links performance incentives to measures of specialty physician performance. The program is based on the premise that doctors want more patients. Its goal is to develop a single set of measures and create a single data repository.

Aetna has found that it must reach out to many providers to encourage them to participate because of the multiple measurement tools that are already being used. In addition, Aetna has found that, because the Aexcel program involves physicians, many issues involving due process and appeals rights must be addressed. Dr. Brennan advocated moving quickly but deliberately to develop NQF-endorsed ™ claims-based efficiency measures that are consumer friendly and that are supported by providers.

September 27, 2007 – Panel II: Medications and Quality: A National Perspective
Participants: Rebecca Burkholder, JD, Marianne Ivey, PharmD, MPH, Michael Rapp, MD, JD
Moderator: Bruce McWhinney, PharmD

Bruce McWhinney, PharmD, began this panel discussion by noting that medications have been at the center of safety initiatives since the early 1990s, and although there has been a lot of progress in the area of drug safety, much remains to be done. With the high rate of prescription drug use in the general and Medicare populations, medication safety is an especially urgent issue. NQF is helping address this issue through its medication therapy management project. The goal of the project is to develop national voluntary consensus standards for the reporting of therapeutic drug management quality.

Michael Rapp, MD, JD, spoke about CMS's challenges in developing medication quality measures. The Part D program does generate data that could be useful in developing medication measures. However, there are several gaps in the data, such as a lack of diagnosis or procedure codes that need to be addressed before the data could be used. CMS is actively working and is committed to addressing these issues.

Rebecca Burkholder, JD, addressed the lack of consumer-friendly information. She stated that one of the reasons that people do not take medications correctly is because they do not have access to information that they can understand. While the care provider is the primary and most trusted source of information on medications, consumers often must sort through other information on their own.

Marianne Ivey, PharmD, MPH, discussed the looming shortage of pharmacists. Studies have predicted that the nationwide shortage could be as many as 160,000 by 2020. A shortage would definitely create challenges for hospitals in maintaining or implementing medication safety policies. She stated "everyone thinks collaboration is a good thing, but clearly there is a shortage of time and leadership."

John M. Eisenberg Patient Safety and Quality Award Presentation

The National Quality Forum and The Joint Commission awarded the 2007 John M. Eisenberg Patient Safety and Quality Awards. The honorees, by award category, were as follows:

Individual Achievement: Darrell Campbell, MD. Dr. Darrell Campbell was the recipient of the Eisenberg Award for Individual Achievement in his role as Henry King Ransom Professor of Surgery and Chief of Staff at the University of Michigan Health System (UMHS). A transplant surgeon, Dr. Campbell has been actively involved in the national leadership of the American College of Surgeons-National Surgical Quality Improvement Program (ACS-NSQIP).

On a regional level, Dr. Campbell has organized a collaborative of 34 Michigan hospitals (Michigan Surgical Quality Collaborative), all of which use the ACS-NSQIP as an infrastructure for quality measurement and improvement. On a local level, Dr. Campbell has served as the UMHS Chief of Staff for the past 7 years, where he has made patient safety the University of Michigan's top priority. Some of the initiatives involved have been institution of a "full disclosure" policy for medical errors, Patient Safety Rounds, establishment of an institutional Rapid Response Team, and redesign of the institution's peer review system. This has resulted in not only a well-publicized, substantial decrease in the University of Michigan's medical malpractice exposure but also, more importantly, a culture shift: creating a direct link between patients' experiences and patient safety and using lessons from claims to improve the quality of clinical care.

Individual Achievement: Flaura Koplin Winston, MD, PhD. Dr. Flaura Koplin Winston was awarded the Eisenberg Award for Individual Achievement for her work to promote patient safety through improved anticipatory guidance of traffic crashes, the leading cause of death and acquired disability among children. Since 1990, Dr. Winston's Research to Action program has led to a 15% reduction of child traffic deaths nationally. This program is unique because it blends disparate research methods, but also because within its scholarly approach it embeds a connection to policy and implementation.

Dr. Winston's key contribution to the field is Partners for Child Passenger Safety (PCPS), an ongoing child-focused crash surveillance system and research and outreach program. This system links an academic medical research team with the insurance industry. Established with State Farm Insurance Companies® in 1997, PCPS incorporates epidemiology, biostatistics, behavioral science, medicine, and engineering.

In response to the program's findings, most notably that children in seat belts were at a 3.5-fold increased risk of serious injury compared with children in child restraints, her team conducted educational, public health, and media campaigns to promote appropriate restraint. The team also created an interactive website for parents in English and Spanish (www.chop.edu/injury). In addition, the team provided the data and participated in advocacy efforts that resulted in upgrades to more than 38 state child restraint laws to include requirements for booster seats and two federal laws on child restraint systems.

Research: Eric Thomas, MD, MPH. Dr. Eric Thomas of the University of Texas Health Science Center at Houston was honored with the research category of the Eisenberg Award. With over 13 years of grant supported research on patient safety, Dr. Thomas has acted as the Principle Investigator of numerous safety focused grants.

He began his patient safety research 5 years prior to the groundbreaking Institute of Medicine report, *To Err is Human*. During that time, he studied the epidemiology and costs of medical errors and adverse events and analyzed the function of our medical malpractice system with Dr. Troy Brennan. The Institute of Medicine relied upon their research to calculate the lower bound of the estimated number of patients who die per year from errors in U.S. hospitals.

With colleagues Drs. Robert Helmreich and Bryan Sexton, Dr. Thomas was awarded funding from the Robert Wood Johnson Foundation to translate a safety culture survey from the field of aviation to healthcare. This grant funded initial development of the Safety Attitudes Questionnaire, now one of the most widely used safety culture assessment tools in the world.

Innovation in Patient Safety and Quality at a Regional Level: Obstetrics Training Team Beth Israel Deaconess Medical Center, Harvard Medical School. The Obstetrics Training Team of Beth Israel Deaconess Medical Center was awarded the Eisenberg Award for Innovation in Patient Safety at the National Level. The team embarked on a project to develop outcome measures that could be obtained from hospital discharge data and would be clinically relevant to all healthcare providers in the field. Working in conjunction with the American College of Obstetricians and Gynecologists, the team developed weighted scores to track the frequency and severity of adverse events related to patients in their department.

A 4-hour training module utilizing Crew Resource Management (CRM) was developed by the team, adapting a version used in the fields of military and commercial aviation. The training regimen focused on communication, resource management, error prevention, and site-specific situation awareness. After 4 months of training, a total of 220 staff members completed the course resulting in a significant improvement in obstetric outcomes, including a reduction in the number of adverse events and claims forwarded to their malpractice carrier, becoming leaders in patient safety at Beth Israel Deaconess Medical Center.

Innovation in Patient Safety and Quality at a Regional Level: Methicillin-resistant Staphylococcus aureus (MRSA) Reduction Program Team Evanston Northwestern Healthcare. Evanston Northwestern Healthcare's (ENH) MRSA Reduction Program Team received the Eisenberg Award for Innovation in Patient Safety at the Local Level. MRSA infection has had rapidly increasing prominence in the U.S. healthcare system since 2000.

ENH started a universal surveillance program for MRSA, which was the first of its kind in North America. This program involved performing nasal swabs for MRSA colonization testing on all daily hospital admissions. A new molecular diagnostic technique called a real-time PCR was used to quickly assess MRSA status. This permitted rapid isolation of affected patients and application of decolonization therapy to remove MRSA bacteria from afflicted persons. The average time of MRSA carrier test turnaround was significantly reduced, patients were treated sooner and the risk of infection of the patient population was decreased

September 27, 2007 – Panel III: Moving Performance Measures Into Electronic Health Record Requirements
Participants: John Loonsk, MD, Blackford Middleton, MD, MPH, MSc
Moderator: Helen Burstin, MD, MPH

John Loonsk, MD, spoke about the national progress toward implementing electronic health record (EHR) systems. He noted that, while progress on the national level has been slow, things are moving forward. To achieve national level implementation of EHR systems healthcare administrators, policymakers, and institutions must focus on obtaining high-quality, reliable clinical data. This will require the continued evaluation of quality measures for inclusion in EHRs, despite the fact that not all data will be available or, if available, standardized. Once standards come forward and are certified, much more progress will be made.

Blackford Middleton, MD, MPH, MSc, spoke about the "high-performance medicine" program developed by Partners HealthCare System, Inc. The goal of this program is to deliver better care to patients. This is accomplished by using and assessing web-based, secure tools called Smart Forms and Quality Dashboards. The tools are integrated into the provider's workflow to help engage them in using decision support in clinical encounters. Smart Forms consolidate data review, decision support, and documentation requirements for particular medical conditions, while Quality Dashboards are condition-specific applications used for quality reporting and population management. The use of dashboard technology, for example, allows the provider to click the mouse and drill down to specific details in the EHR. Both tools have the potential to improve care, demonstrate EHR value to providers, and drive EHR use.

September 27, 2007 – Panel IV: Technology Applications to Enhance Nursing Practice: Quality and Policy Applications
Participants: Pamela Cipriano, PhD, RN, Ann Hendrich, MS, RN
Moderator: Bonnie Jennings, DNSc, RN

This panel discussed two studies funded by the Robert Wood Johnson Foundation. Both studies are designed to target how technology is used in healthcare settings.

Pamela Cipriano, PhD, RN, FAAN, discussed a study titled *Synthesized Approach for Identifying & Fostering Technological Solutions to Workflow Inefficiencies on Medical/Surgical Units*. Medical/Surgical Units were selected for the study because they are the most chaotic (i.e., varying level of patient acuity, various diagnoses, transfers in and out).

Twenty-five medical/surgical units from across the country were selected to participate in the study. Each unit assembled 20-30 people representing those who touched a patient (e.g. nurses, clerks, pharmacists, laboratory personnel, etc.). The group was brought together to brainstorm and identify technological solutions that would improve their work and environment. The following suggestions are a few of the results of the brainstorming sessions.

- Computerized order entry should be incorporated in the medical record.

- Employ global documentation systems that serve the multidisciplinary teams within hospitals. The systems should provide information in real time, and be universal (i.e., can be used by all levels of the healthcare system: physician, nurse, hospital, home health). They should also address language standardization.

- Interactive, multi-functional devices at the patient's bedside would help improve care coordination.

- Interpreter services are not always available. Developing a virtual interpreter would facilitate better communication.

Ann Hendrich, RN, MS, FAAN, discussed a study titled *How Medical Surgical Nurses Spend their Time: A Multi-Site Study*. She noted that this was a presentation of a quantitative study that overlapped with the previous presentation. Often, inefficiency drives up costs rather than hospital programs or staff. More than 50% of a nurse's time is doing administrative tasks rather than patient care.

This was a motion study to identify exactly how nurses move and where they spend their time. Four methodologies were used:

Track A: PDA for nurse to record movements

Track B: Nurses were given a PDA that vibrated about 22 times a day to ask the nurse what they were doing and where they were. It was found that the smallest amount of time was spent on performing nursing assessment of patients.

Track C: A GPS system was used to track nursing movement and time. They found that this was the most difficult, because nurses do not stay in one place long enough for the system to identify where they were.

Track D: This tracked nurse physiology – how far and how hard they worked on the unit. It was found that on average a nurse travels about 3-5 miles a day on the unit. One of the reasons nurses fail to rescue patients is because they are away from the patient so much.

The study showed that technology cannot be an overlay on the current inefficient system, which does not support time in patient care. In addition, it showed that changes must result in nurses being able to spend more time on direct patient care rather than administration

September 28, 2007 - Board of Directors Meeting

For her report to the Board of Directors Dr. Corrigan presented a list of ongoing NQF projects and a list of completed NQF projects. (See appendix A.)

Evaluation of the Conference

The National Quality Forum employed a number of strategies to evaluate and document the participation, experience, and outcomes of the 2007 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

◊ Great balance of topics. I also appreciated the Eisenberg presentations.

◊ The messages around Quality are too important to be rendered to memory. No presenter should get away without presenting handouts. Communication: Multimedia is part of the success.

◊ Speakers had very little humor. Few anecdotes, not enough scientific evidence to support presenters and far too much policy alphabet soup: need to think more about what they want to communicate and why. Great Q&A.

◊ Educational sessions are usually excellent and attendees hate to miss even one. Yet breaks are very limited and day is extremely long. It would be helpful if breakouts were offered or conference was divided into 2 days. Also, the meeting is very well done, from food to packets. THANKS!!

◊ Better than last year. Good examples of best practices and with enough detail in most cases.

◊ Best Policy Conference so far!!! Excellent content, presenters, and pace.

◊ Panel on Community Partnerships is too esoteric—maybe better in future when there is more to be said.

◊ Eisenberg Awards were definitely highlight of conference.

◊ Please have handouts for all speakers in the binder or at least at our fingertips. Enjoyed the last panel on nursing the most. I would have moved that up in the day so more people could experience it.

◊ Lower rated presentations provided only theory. Should pair these with frontline presentations.

◊ Stay on agenda: better time management. If the last speaker cancels, don't spread out the day.

Appendix A

NQF Portfolio of Ongoing Projects
Updated September 2007

PRIORITIES & GOALS

Establishing Priorities, Goals and a Measurement Framework for Assessing Value Across Episodes of Care
Program Director: Karen Adams, PhD

Brief Description: The absence of national priorities and goals and a vision for how to move to a system with defined accountabilities impedes the efforts of those involved in all facets of performance measurement and reporting. The NQF has convened a Steering Committee whose primary charge is to establish national priorities and 3-5 year performance goals for two common chronic conditions, and to the extent possible, identify measures that can be used to assess progress in meeting each goal. The project will also develop a comprehensive measurement framework for chronic care episodes that will likely be applicable to many chronic conditions. The overall purpose is to move towards a better alignment of measurement development and reporting activities with national priorities and goals, to address critical gaps in the quality measurement agenda, and to begin defining comprehensive, longitudinal performance metrics—focusing on extended episodes of care that include quality and resource use, and are reflective of both care processes and patient outcomes.

Current Status: The Steering Committee's proposed measurement framework for evaluating efficiency—defined as quality and cost—across episodes is planned for release by the end of 2007.

Funders: The Robert Wood Johnson Foundation, The Commonwealth Fund

PRIORITIES PARTNERS

National Priorities Partners and Setting National Priorities and Goals
Program Director: Karen Adams, PhD

Brief Description: The absence of national priorities and goals impedes the efforts of those involved in all facets of performance measurement and reporting. The NQF Board of Directors recently approved expansion of the NQF mission to include working toward national priorities and goals for performance measurement and public reporting. However, NQF recognizes that priority-setting must be a collaborative process with other key stakeholders who engage in priority-setting efforts of their own.

Therefore, NQF is establishing a committee to be known as *National Priorities Partners*, which will include representatives of major national organizations that represent "effecter arms" for purposes of implementation. NQF will serve as the convener of the *National Priorities Partners* in its work to identify a small core set of priorities where there is compelling evidence that opportunities exist to produce sizable improvements in health and healthcare. In addition, the *National Priorities Partners* will serve in an advisory capacity to the NQF Board of Directors to continue efforts to clarify NQF roles and responsibilities versus those of other key organizations on the quality landscape.

Current Status: Representatives for the *National Priorities Partners* have been identified and invited to participate in this initiative. Replies have been requested by September 24, 2007, with the first meeting scheduled January 10, 2008, in Washington, DC.

Funders: NQF will seek funders to support this effort.

PERFORMANCE MEASURES, PRACTICES, AND FRAMEWORKS

National Voluntary Consensus Standards for Ambulatory Care Quality Measurement and Reporting—Phase 3
Program Director: Reva Winkler, MD, MPH

Brief Description: Ambulatory (outpatient) care is the primary venue or mode of U.S. medical care, with well over a billion visits to physician offices and hospital outpatient and emergency departments each year. Despite its centrality to healthcare, there are few agreed upon quality measures specifically aimed at measuring the performance of outpatient care providers. In April 2004, NQF conducted a workshop (phase 1) to identify priority areas for which standardized performance measures should be sought. The 10 priority areas identified were: patient experience with care, coordination of care, asthma, prevention (primary and secondary, including immunization), medication management, heart disease, diabetes, hypertension, depression, and obesity. During phase 2, NQF endorsed 36 "physician-focused" voluntary consensus standards for ambulatory care performance through expedited consideration of an existing array of ambulatory care measures drawn from the AMA Physician Consortium for Performance Improvement (PCPI), CMS, NCQA, and AHRQ; phase 2 included measures in two areas (prenatal and bone conditions) and five of the priority areas. In mid-2005 through 2007, NQF undertook phase 3 of the project, which included a "Call for Measures" in each identified priority area, with measures endorsed during phase 2 re-examined against all available measures received in response to the Call for Measures. Phase 3 (which includes three cycles) includes development of an index(es) and concludes with a Workshop to identify research and development needs.

In cycle 2 of the multi-year, multiphase ambulatory care project, NQF considered candidate measures in the priority areas of bone and joint conditions, diabetes, heart disease, mental health and substance use disorders, and prenatal care. In cycle 3, NQF evaluated candidate measures of patient experience with care and special settings of care (ambulatory surgical centers). Additionally, the RWJF asked NQF to examine measures considered in Phases 2 and 3 through the lens of care disparities. The deliverable will be a set of performance measures that is "disparities-sensitive" and is a comprehensive and broadly applicable in ambulatory settings.

Current status: NQF endorsement is expected in November 2007.

Funder: The Robert Wood Johnson Foundation, Centers for Medicare & Medicaid Services

National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures
Program Director: Reva Winkler, MD, MPH

Brief Description: Ambulatory care has been an especially active area of performance measurement, though not all aspects of care in that setting have benefited equally from measure development and use, specifically the performance of specialty care providers. At the request of CMS, NQF considered clinician-level (including physicians and other licensed independent practitioners) measures for eye care; dermatologic conditions, including cancer; osteoporosis; gastrointestinal conditions, including GERD; geriatric conditions, including falls, incontinence, and coordination of care; and emergency care, including both patients discharged by the emergency department and patients admitted to the hospital from the emergency department.

Current Status: This project was carried out in conjunction with Phase 3, Cycle 3 of the ambulatory care project. NQF endorsement is expected in November 2007.
Funder: Centers for Medicare & Medicaid Services

Endorsing a Framework and Preferred Practices for Measuring and Reporting Culturally Competent Care Quality
Program Director: Fatema Salam, MPH

Brief Description: In 2002, the Institute of Medicine (IOM) released the report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, which found that racial and ethnic minorities often receive lower quality of care than their White counterparts, even after controlling for factors such as insurance, socioeconomic status, comorbidities, and stage of presentation.

Efforts to define culturally competent care are already in progress, catalyzed by the Office of Minority Health's publication of standards for culturally and linguistically appropriate services (CLAS) for health care organizations. One important—though not the sole—contributor to these disparities is a lack of culturally competent care. Efforts to define culturally competent care are already in progress, but significant knowledge gaps exist about the direct relationship between cultural and linguistic competence and improved health outcomes. Measurement and reporting are needed to ensure that culturally competent care can be translated into i) improved health outcomes and more patient-centered care for patients and ii) actionable initiatives for providers that result in meaningful improvement. While various frameworks have been proposed for cultural competence research or assessment, to bring the cultural competency movement to the next level requires consensus on a framework for measuring and reporting the quality of culturally competent care. From this framework, preferred practices can be derived and/or performance measures identified (or developed) and endorsed.

Current Status: The 15-month project will convene a Steering Committee and release a Call for Frameworks and Preferred Practices in September 2007. NQF-endorsement™ is expected in fall 2008.

Funders: The Commonwealth Fund, California Endowment

Identifying Core Data Elements for Electronic Healthcare Information Systems
Program Director: Daniel Rosenthal, MD, MS, MPH

Brief Description: While recent initiatives from the AQA and HQA have specified measures that can be populated with readily-available administrative data, performance can be characterized more accurately when clinical data are used. In an effort to define how health information technology (HIT) can effectively support quality improvement, the NQF will convene a panel of approximately 20 experts. This Health Information Technology Expert Panel (HITEP) will be tasked to 1) develop a set of common data elements to enable automated electronic health record (EHR) performance measure reporting, 2) establish a priority order for existing AQA and HQA measures, and 3) determine mechanisms within clinical workflows to provide decision support and gather the resulting performance data. NQF will ultimately incorporate the panel's recommendations into existing endorsement criteria to reinforce the use of the selected data elements to allow quality measures to be effectively embedded in EHRs.

Current Status: The expert panel was convened in May 2007 and will be reconvened on September 24, 2007.

Funder: Agency for Healthcare Research and Quality

National Voluntary Consensus Standards for Emergency Care
Program Director: Del Conyers, MPH

Brief Description: Demand and capacity issues have contributed to increased patient wait-time and decreased physician productivity, and they place patients at risk for poor outcomes. A quality initiative that seeks to establish a standardized measurement and reporting system of the performance of emergency care providers and systems will effectively improve the care of patients and reduce excessive healthcare costs. To that end, NQF seeks to identify and endorse measures for public accountability and quality improvement related to emergency care. This is a two-phase project. In Phase I, Measures of Emergency Department Transfer, NQF is considering performance measures in a limited area, emergency department transfers, only. These measures address the emergency care provided to patients who are transferred from an emergency department to another acute care hospital or emergency department. In Phase II, NQF will formally solicit measures that address other aspects of hospital-based emergency department that address pressing quality issues such as patient wait time, overcrowding, boarding, and diversions.

Current Status: NQF endorsement is expected for Phase I in November 2007 and Phase II in summer 2008.

Funder: Centers for Medicare and Medicaid Services

National Voluntary Consensus Standards for End-Stage Renal Disease
Program Director: Karen Pace, PhD, RN

Brief Description: The prevalence of end-stage renal disease (ESRD) has continually increased over the past two decades. More than 450,000 Americans suffer from kidney failure (ESRD) and require either kidney dialysis or transplantation to live. In 2003, the average length of stay per admission was approximately 13.8 days, and 82,588 ESRD patient deaths occurred in the United States. CMS reports that hospitalization costs account for approximately 40% of the cost to Medicare for healthcare for this patient population. In 2002, total Medicare costs for the ESRD program were $17 billion, an increase of 11 percent over costs in 2001. Due to the rising prevalence of ESRD, it is imperative that quality initiatives be established to ensure quality, efficient ESRD care be provided in the United States. NQF is reviewing voluntary consensus standards relevant to the care of patients with ESRD who require dialysis or kidney transplantation.

Current Status: NQF endorsement is expected in November 2007.

Funder: Centers for Medicare & Medicaid Services

National Voluntary Consensus Standards for the Reporting of Healthcare-associated Infection Data
Program Director: Merilyn Francis, RN, MPP

Brief Description: Healthcare-associated infections (HAI) are a major public health problem in the United States. HAI are the most common complication affecting hospitalized patients, with between 5 and 10% of inpatients acquiring one or more infections during their hospitalization. Overall, an estimated 2 million hospital-acquired HAIs occur each year in the United States, accounting for an estimated 90,000 deaths and adding $4.5 to $5.7 billion in healthcare costs. Experts generally believe that at least 20-30% of such infections are preventable. This project seeks to achieve consensus on a comprehensive set of national voluntary consensus standards for the public reporting of healthcare-associated infections data in the United States.

Current Status: NQF endorsement ™ is expected in November 2007.

Funders: Texas Medical Institute of Technology, with additional support from Association for Professionals in Infection Control and Epidemiology and the Society for Healthcare Epidemiology of America.

National Voluntary Consensus Standards for Hospital Care: Additional Priority Areas—2007
Program Director: Melinda Murphy, RN, MS, CAN

Brief Description: To date, the National Quality Forum has endorsed100 voluntary consensus standards for measuring the performance of acute care hospitals. This project was undertaken at the request of the Agency for Healthcare Research and Quality to seek additional voluntary consensus standards for measuring the performance of the nation's general acute care hospitals, including measures of 1) morbidity and mortality, 2) anesthesia and surgery, 3) utilization rates for risky or often unnecessary procedures, 4) surgical volume and mortality, 5) readmission rates and length of stay (LOS) rates, 6) pain assessment, and 7) pediatric asthma. The project is proceeding with five Technical Advisory Panels addressing patient safety, pediatrics, surgery and anesthesia, length of stay and readmission, and an approach to public reporting; a Composite Steering Committee is deliberating an approach to evaluation of composite measures and will consider composite measures submitted.

Current Status: The Consensus Development Process for the majority of the work is expected to commence by December 2007, though readmission/length of stay will advance earlier and the approach to public reporting is scheduled to begin the CDP in late winter 2008.

Funders: Agency for Healthcare Research and Quality (AHRQ) with additional funds provided by the Alliance for Pediatric Quality, America's Health Insurance Plans, and Blue Cross Blue Shield Association.

National Voluntary Consensus Standards for Hospital Care: Specialty Clinician Performance Measures
Program Director: Lisa Hines, BSN, MS

Brief Description: Despite the expanding list of NQF-endorsed™ consensus standards assessing the quality of hospital care, there are critical aspects of hospital care not being addressed. Various stakeholders have recognized a need to fill in the gaps of hospital-based measure sets, particularly in the area of specialty clinician (physician and other licensed independent practitioners) hospital care. Recent initiatives have focused on developing standardized measurement and reporting systems for physician specialties. NQF reviewed voluntary consensus standards to assess the quality of care provided by specialists in hospital settings in the United States in the areas of stroke and stroke rehabilitation; perioperative prophylaxis of thromboembolic disease and infection; and emergency care, including both patients discharged by the emergency department and patients admitted to the hospital from the emergency department.

Current Status: NQF endorsement was received in May 2007. The final report is expected to be published in December 2007.

Funder: Centers for Medicare & Medicaid Services

National Voluntary Consensus Standards for Patient Safety and Communication Practices for Laboratory Medicine
Program Director: Kate Blenner

Brief Description: The laboratory is an integral part of the continuum of care, providing services and information critical to guiding clinical decision-making and ensuring good patient outcomes. While laboratory medicine professionals have been active in quality improvement efforts, good performance in laboratory medicine requires the involvement of all providers. The pre- and post-analytic phases of testing—the processes leading up to and immediately following the execution of a diagnostic test—are critical leverage points for patient safety due to the level of communication and shared responsibility across entities and the resulting potential for error.

This project seeks to achieve voluntary consensus on a set of effective, well-specified patient safety and communication practices for the pre- and post-analytic stages of laboratory diagnostic services.

Current Status: The Call for Nominations and Call for Practices are expected to close in early October. NQF endorsement of the preferred practices is expected in May 2008.

Funder: Centers for Disease Control and Prevention

Endorsing a Framework for Multi-Faceted Physician Competency Assessment
Program Director: Meetal Desai, MPP

Brief Description: While much of the current quality focus has been on physician-level performance measurement, a critically important parallel track has evolved that assesses physician competency to practice in their designated specialties. The American Board of Medical Specialties, along with their member boards, has developed and evolved certification and maintenance of certification (MOC). The six general competencies that have been deemed necessary for physician specialists are 1) Patient care; 2) Medical knowledge; 3) Practice-based learning and improvement; 4) Interpersonal and communications skills; 5) Professionalism; and 6) Systems-based practice. From this framework, preferred practices can be derived and/or performance measures identified (or developed) and endorsed.

Current Status: The 10-month project will convene a Steering Committee and release a Call for Frameworks and Preferred Practices by December 2007. The project is expected to be completed in Summer 2008.

Funders: American Board of Internal Medicine, American Board of Family Medicine, American Board of Surgery, American Board of Pediatrics, American Board of Ophthalmology

National Voluntary Consensus Standards for Perinatal Care
Program Director: Kate Blenner

Brief Description: Pregnancy and childbirth is the second most common reason for admission to a hospital, with 4.2 million childbirth-related hospital stays recorded in 2005. Pregnancy- and childbirth-related procedures accounted for the five most common procedures performed on patients age 18-44, and the most common procedures performed on infants were those associated with birth.

Additionally, maternity and neonatal care involves multiple ambulatory encounters with obstetricians, midwives, pediatricians, and other care practitioners. Given the frequency of pregnancy and childbirth care encounters, ensuring high-quality Perinatal Care is critical. This project seeks to achieve national voluntary consensus on a set of effective, well-specified performance measures to assess the quality of Perinatal Care services; measures considered will address care provided by practitioners, such as physicians and midwives, as well as care provided by facilities, including hospitals and free-standing birthing centers.

Current Status: This project is expected to finalize endorsement of performance measures in June 2008. The Call for Nominations and Call for Measures are expected to be released by the end of September 2007.

Funder: Hospital Corporation of America

Evidence-based Practices to Treat Substance Use Conditions
Program Director: Karen Pace, PhD, RN

Brief Description: This project, funded by the Robert Wood Johnson Foundation, seeks to achieve national voluntary consensus on a set of effective, well-specified practices for the treatment of substance use conditions. The project builds on the recommendations from a 2004 workshop on evidence-based treatment practices that are sufficiently robust for widespread use.

Current Status: In May 2007, a set of 11 practices for the treatment of substance use conditions was endorsed. The final report will be available September 2007.

Funder: The Robert Wood Johnson Foundation

National Voluntary Consensus Standards for Therapeutic Drug Management Quality
Program Director: Terri Smith Moore, RPh, PhD

Brief Description: Advances in pharmaceutical science and technology are among the most important achievements of modern healthcare. Significant numbers of patients have improved quality of life, and hundreds of thousands of patients with previously fatal diseases now live with controlled chronic conditions with only transient acute illness due to modern drug treatments. Appropriate drug therapy management has significant impact on patient safety, equity, effectiveness, efficiency, and other domains of quality. Despite the past decade's explosion of activity in the measurement of healthcare performance, there has been relatively little focus on therapeutic drug management quality and its impact more broadly on overall patient care quality.

Through this project, NQF will endorse a comprehensive framework; identify and endorse preferred practices and performance measures to address the domains of the framework; and make recommendations regarding priority areas for research and development when there are measurement gaps.

Current Status: NQF endorsement of the framework and preferred practices is expected by December 2007. NQF endorsement of the performance measures is expected in Spring 2008.

Funders: Pfizer, with United HealthCare and the Veterans Health Administration

National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism (VTE)
Program Director: Melinda Murphy, RN, MS, CAN

Brief Description: Venous thromboembolism (VTE), which encompasses deep vein thrombosis (DVT) and pulmonary embolism (PE), is the most common preventable cause of hospital death. Recent estimates show that over 900,000 Americans suffer VTE each year, with about 400,000 of these being DVT and 500,000 being manifest as PE. In about 300,000 persons, PE proves fatal; it is the third most common cause of hospital-related deaths in the United States. Despite the fact that several clinical interventions are known to be effective in preventing and treating VTE, only one third of all patients at risk for VTE who are appropriate candidates for prophylactic treatment actually receive such treatment. This project 1) developed and endorsed performance measures to assess the quality of care for persons at risk for VTE; 2) achieved consensus on evidence-based preferred practices to prevent VTE through the evaluation and treatment of persons at risk for VTE; 3) identified model organizational policies and procedures for the prevention and care of persons at risk for VTE; and 4) catalyzed the adoption and use of these best practices, performance measures, and model policies in every care setting.

Current Status: The initial phase of this project has resulted in the endorsement of a policy statement, key characteristics of preferred practices, and two performance measures. The second phase of the project will endorse additional performance measures in Spring 2008. The initial volume published in January 2007.

Funder: Sanofi-aventis

EDUCATION AND OUTREACH

Moving Closer to Voluntary Consensus Standards for Care Coordination – Implementation Conference 2008
Program Director: Dwight McNeil, PhD

Brief Description: Care coordination across settings and providers is a quality of care and patient safety issue. To date, performance measurement has focused on the management and subsequent outcomes for specific diseases managed in specific sites of care (e.g., diabetes management in the physician office; acute myocardial infarction in the hospital). As part of its ambulatory care work, NQF endorsed a framework and standardized definitions for care coordination in May 2006. The next step is to act on these recommendations and facilitate the development of much needed performance measures in this pivotal area of healthcare. It will engage experts and members in dialogue on multi-stakeholder viewpoints on the five elements of the framework and on implementation successes. Products, including an Issue Brief and conference proceedings, will educate and promote the need for the next stage in the development of standards that should include an expert group to agree upon the critical concepts that will provide the foundation for the development of performance measures that reflect the NQF-endorsed™ framework for care coordination.

Current Status: This project will highlight care coordination as the theme of the Implementation Conference in Spring 2008.

Funder:

Guidelines for use of Performance Measures and the Individual Clinician Level – A Workshop
Program Director: Dwight McNeill, PhD, MPH

Brief Description: In recent years, interest has grown in the application of performance measures at the level of individual physicians and other clinicians. The Centers for Medicare & Medicaid Services (CMS) has established the Physician Quality Reporting Initiative (PQRI) and efforts are underway to expand this measurement and reporting system. However, while there has been a great deal of experience in developing, testing, and applying performance measures at the level of health plans, hospitals, and group practices, there has not been the same level of experience at the individual clinician level. In applying performance measures at the individual level, numerous challenges arise including statistical; risk-adjustment and attribution; and unintended consequences.

This workshop seeks to identify key concepts that will guide the development of guidelines for the use of performance measures at the individual clinician level.

Current Status: The workshop is in the planning phase, with naming of the co-chairs completed and naming of the expert panel near completion. The workshop is scheduled to take place in April 2008.

Funders: American Board of Internal Medicine, Eli Lilly and Company

Cost and Price Reporting: A Resource Guide for Debate
Program Director: Merilyn Francis, RN, MPP

Brief Description: Momentum is building to use cost and price reporting as a key strategy to engage consumers in healthcare decision making and to control healthcare spending. President Bush's August 22, 2006, Executive Order requires all federal healthcare programs to promote transparency of price information as of January 2007. Similarly, many states make, or are actively exploring initiatives to make, cost and price information publicly reported. Currently, however, there is little consistency or coordination of the underlying definitions and principles related to transparency of cost and price information, and a good deal of controversy as to the meaningfulness of some types of cost and price information being sought. The principle objective of this project is to identify a common language and to better understand the key requirements for useful, feasible, reliable, and comparable cost and price reporting.

Current Status: Through this project an Issue Brief outlining the salient issues of relevance to consumers was released at the beginning of September 2007 as well as the in-depth background paper that provided a "lay of the land" of current reporting initiatives and key criteria for evaluating the effectiveness of different reporting strategies.

Funder: The Robert Wood Johnson Foundation

NQF Portfolio of Completed Projects
Updated September 2007

Consensus Projects

A National Framework for Healthcare Quality Measurement and Reporting—A Consensus Report

In December 1999, the NQF appointed a nine-member Strategic Framework Board (SFB) with a charge to propose a national strategy for quality measurement and reporting. This document builds on that work to identify the NQF's short- and long-term objectives related to a national framework for healthcare quality measurement and reporting as well a principles and policies to guide the development of the framework. **Published July 2002**

National Priorities for Healthcare Quality Measurement and Reporting—A Consensus Report

This report builds on the Institute of Medicine's 2003 report, *Priority Areas for National Action: Transforming Health Care Quality*, and presents the 23 NQF-endorsed™ priorities for healthcare quality measurement and reporting across the continuum of care. The priorities are organized into two infrastructure priorities, five process of care priorities, and 15 healthcare condition priorities, with one overarching, highest priority across all areas—reducing disparities in health and healthcare quality in vulnerable populations. **Published December 2004**

National Voluntary Consensus Standards for Ambulatory Care: An Initial Physician-focused Performance Measure Set

More than a billion visits to physician offices and hospital outpatient and emergency departments take place each year. Although ambulatory (outpatient) care embraces a wide range of health conditions, services, and care settings—and is the primary site in the United States where patients receive care—there are few agreed upon quality measures specifically aimed at measuring the performance of outpatient care providers. This report details 42 NQF-endorsed™ consensus standards for ambulatory care, representing an initial set of physician-focused, ambulatory care voluntary consensus standards conducted under "Phase 2" of NQF's ambulatory care work. **Published April 2006 (electronic only)**

National Voluntary Consensus Standards for Ambulatory Care Quality Measurement and Reporting—Phase I
The ambulatory care setting (outpatient care) is the principal venue for delivering medical care across the continuum from primary care to end of life care. Measuring and reporting the quality of outpatient services have become a focus in the healthcare industry as evidence accumulates on the role of underuse, overuse or misuse of services and treatments in unnecessary hospitalizations and poor patient outcomes. Based on a meeting held in April 2004, this initial phase establish consensus around 10 priority topics within the ambulatory care setting that would benefit from the standardization of performance measurement sets and public reporting mechanisms. **Meeting summary made available on website**

National Voluntary Consensus Standards for Ambulatory Care: Phase 3, Cycle 1
In May 2006, NQF endorsed 37 consensus standards in the priority areas of asthma/respiratory illness, medication management, obesity, hypertension, prevention (including screening and immunization), and a framework for measuring coordination of care as part of Phase 3, Cycle 1 of the ambulatory care project. **In press**

Standardizing Quality Measures for Cancer Care
More than 8 million Americans each year require cancer care. The IOM recently concluded that people with cancer do not always receive care that is known to be effective; mechanisms to consistently measure the provision of effective and high-quality care do not exist; and systematic improvements in cancer care quality should rely on ways to distinguish high-quality care. This project 1) established a framework to identify, evaluate, and endorse national voluntary consensus standards for cancer care quality measures and 2) identified a framework to guide reporting based on and implementation of the consensus standards. The project initially focused on sets of voluntary consensus standards for quality of care in three areas: diagnosis and treatment of breast cancer, diagnosis and treatment of colorectal cancer, and symptom management/end-of-life care. **In press**

Voluntary Consensus Standards for Cardiac Surgery
Heart disease is the leading cause of death and disability in the United States and one of the 20 healthcare quality improvement priorities that the Institute of Medicine has recommended for focused national attention. Coronary artery bypass graft surgery is now performed over 700,000 times per year in U.S. hospitals, while heart valve surgery is performed over 100,000 times per year. Cardiac surgery performance and outcomes have been of considerable public interest and have featured heavily in a number of efforts aimed at public reporting of healthcare quality since the 1980s.

This project endorsed 21 performance measures for cardiac surgery that can be used for external accountability and public disclosure and for internal reporting and quality improvement. **Published February 2005**

National Voluntary Consensus Standards for Adult Diabetes Care—A Consensus Report
The NQF has endorsed as voluntary consensus standards a set of performance measures for adult diabetes care for both accountability and quality improvement purposes. The measure sets were jointly developed in April 2002 by the National Diabetes Quality Improvement Alliance, a collaboration of 13 national, public and private healthcare provider, accreditation, regulatory, research, and patient advocacy organizations. **Final report published in October 2002**

2005 Update: Voluntary Consensus Standards for Adult Diabetes Care
The NQF has endorsed as voluntary consensus standards a set of performance measures for adult diabetes care for both accountability and quality improvement purposes. This project is establishing consensus on updates to that measure set, as proposed by the National Diabetes Quality Improvement Alliance, a collaboration of 13 national, public and private healthcare provider, accreditation, regulatory, research, and patient advocacy organizations, as well as measures from AHRQ. In May 2005, NQF endorsed nine consensus standards for public reporting of diabetes care; 37 quality improvement-only and community-level proposed consensus standards are pending. **Published in April 2006 (incorporated in ambulatory care project)**

Voluntary Consensus Standards for Home Healthcare
More than 7 million Americans receive care in their homes each year at a cost of more than $36 billion. Home healthcare services are delivered at home to patients who are recovering from care in hospitals or nursing homes; patients who are disabled; and persons who are chronically or terminally ill but in need of medical, nursing, or therapeutic treatment as well as assistance with the essential activities of daily living. This project endorsed 15 performance measures that will facilitate standardized comparison of quality of home healthcare providers in communities across the country. **Published October 2005**

National Voluntary Consensus Standards for Hospital Care: Additional Priority Areas—2005-2006
In 2002-2003, NQF endorsed an initial set of 39 measures in eight priority areas. This project is being undertaken at the request of the CMS in order to supplement that set with measures in two additional priority areas: coordination of care and mortality (acute myocardial infarction, heart failure, and pneumonia). **Published July 2006**

Hospital CAHPS®
Standardized measurement and reporting of the quality of hospital services from the patients' perspectives is a high priority. The Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) have developed a standardized consumer survey tool—HCAHPS®—that can be used by hospitals to collect comparable data for public reporting of hospital patient perspectives of their care experience care they received. This project, funded by CMS, resulted in the endorsement of HCAHPS,® as well as several research and implementation recommendations. **Published October 2005**

National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set—A Consensus Report
While the growing interest in quality measures for hospitals increases the possibilities for measuring and improving hospital quality, it also increases the potential for misdirected or redundant activities, conflicting demands by different interests, and confusion about relevant measures. This project assessed and endorsed an initial set of 39 measures in eight priority areas that were chosen from already existing measures and that are reasonable indicators of hospital quality and are useful to consumers, purchasers, hospitals, and quality improvement organizations alike. **Published September 2003**

A Comprehensive Framework for Hospital Care Performance Evaluation—A Consensus Report
This report, developed as part of the NQF project on national voluntary consensus standards for hospital care, established a comprehensive framework and standardized process for hospital quality measurement and reporting, including identifying where research is needed to develop appropriate measures and recommending a process for updating the initial set. **Published May 2003**

Voluntary Consensus Standards for Nursing-Sensitive Performance Measurement
Nursing care is critical to the quality of patient care and the success of any healthcare delivery system. This project 1) identified a framework for how to measure nursing care performance, with particular attention to the performance of nurses as teams and their contributions to the overall healthcare team; 2) endorsed a set of 15 consensus standards for evaluating the quality of nursing care; and 3) identified gaps in the set for which measures should be developed, as well as research that should be undertaken to refine existing measures. **Published October 2004**

Establishing a Tracking System for Implementation of the NQF-endorsed™ Voluntary Consensus Standards for Nursing Care
In 2004, NQF endorsed an initial set of 15 performance measures to evaluate the quality of nursing care. This follow-up project, funded by the Robert Wood Johnson Foundation, will establish a tracking system for capturing and reporting adoption and use of the NQF-endorsed consensus standards; identify the successes and challenges experienced by users of the standards; and identify technical and other issues that are barriers to uniform implementation and communicate these to the measure developers and other key stakeholders.
Available on the website

Voluntary Consensus Standards for Nursing Home Care
This project will identify a set of performance measures for long-term and post-acute skilled nursing facilities, which is to be used for public reporting and quality improvement. The project also examined gaps in existing measure sets that may be appropriate for future research and/or new measure development.
Published April 2004

National Framework and Preferred Practices for Palliative and Hospice Care
Palliative care is provided across a wide variety of settings and professional fields. It incorporates symptom control, including pain management, supportive care, respite care, rehabilitation, and terminal care. Over the past few years, demand for hospice and palliative care services has grown tremendously. In May 2004, the National Consensus Project—overseen by the American Academy of Hospice and Palliative Care, Center to Advance Palliative Care, Hospice and Palliative Nurses Association, Last Acts Partnership, and National Hospice and Palliative Care Organization—reported on"clinical guidelines" for palliative care. This project utilized the NCP document as the starting point to endorse a national framework for palliative and hospice care and a set of preferred practices derived from that framework, with the ultimate goal of utilizing the framework and practices to endorse a set of voluntary consensus standards for palliative and hospice care quality measurement and reporting. **Published January 2007**

Standardizing a Patient Safety Taxonomy
Although efforts to identify and report information related to patient safety have multiplied, the healthcare system still has no standardized framework for classifying the data that would enable comparisons and analyses of data from across the many public and private reporting systems. After considering several taxonomies and classification schemes that are in current use or development, this project endorsed the Patient Safety Event Taxonomy developed by the Joint Commission on Accreditation of Healthcare Organizations.

The taxonomy is intended to serve as a single, standardized taxonomy for classifying patient safety data to which existing reporting systems can be mapped and that can be integrated into clinical software so as to form a basis for comparable information across reporting systems and patient safety efforts. **Published January 2006**

Safe Practices for Better Healthcare—A Consensus Report
This project identified a list of 30 evidence-based "safe practices" that should be universally implemented in applicable care settings to reduce the risk of harm resulting from the processes or environments of care. The set of practices focuses on those practices that 1) have strong evidence that they are effective in reducing the likelihood of an adverse event; 2) are likely to have a significant impact on patient safety if fully implemented; and 3) are usable by consumers, providers, purchasers, and researchers. **Published May 2003, Update published March 2007**

Serious Reportable Events in Healthcare—A Consensus Report
The NQF has identified and endorsed a set of serious preventable adverse events in healthcare that can be used to standardize data collection and reporting of these events within and across states. Previously, standardized definitions and measures of avoidable, serious adverse events did not exist. **Published March 2002, Update published March 2007**

National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism (VTE)
Venous thromboembolism (VTE), which encompasses deep vein thrombosis (DVT) and pulmonary embolism (PE), is the most common preventable cause of hospital death. Recent estimates show that over 900,000 Americans suffer VTE each year, with about 400,000 of these being DVT and 500,000 being manifest as PE. In about 300,000 persons, PE proves fatal; it is the third most common cause of hospital-related deaths in the United States. Despite the fact that several clinical interventions are known to be effective in preventing and treating VTE, only one third of all patients at risk for VTE who are appropriate candidates for prophylactic treatment actually receive such treatment. This project 1) developed and endorsed performance measures to assess the quality of care for persons at risk for VTE; 2) achieved consensus on evidence-based preferred practices to prevent VTE through the evaluation and treatment of persons at risk for VTE; 3) identified model organizational policies and procedures for the prevention and care of persons at risk for VTE; and 4) catalyzed the adoption and use of these best practices, performance measures, and model policies in every care setting. The initial phase of this project has resulted in the endorsement of a policy statement, key characteristics of preferred practices, and two performance measures. The second phase of the project will endorse additional performance measures in Spring 2008. **Initial volume published in January 2007**

Workshop Proceedings

ACE Inhibitors vs. ARBs Performance Measure—Workshop
In 2002, NQF endorsed two measures, developed jointly by The Joint Commission and CMS, addressing use of angiotensin-converting enzyme (ACE) inhibitor drugs for patients with left ventricular systolic dysfunction complicating acute coronary syndrome and heart failure. Ongoing research has identified a new class of drugs, angiotensin receptor blockers (ARBs), with similar effects as ACEIs. Several large-scale clinical trials, notably the CHARM and VALIANT studies, have compared ACEIs and ARBs in patients with heart failure and myocardial infarction. The August 2004 update of the American College of Cardiology/American Heart Association Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction include the use of ARBs in patients who are intolerant of ACEIs. Co-sponsored with AHRQ in November 2004, this workshop examined the current evidence on use of ACEIs and ARBs to address whether the currently endorsed measures should be updated to include broader use of ARBs instead of or in addition to ACEIs.
Proceedings available online

Integrating Behavioral Healthcare Performance Measures Throughout Healthcare—Workshop
Mental illness and substance use disorders afflict patients in all clinical care settings. To date, efforts to develop and implement performance measures for behavioral healthcare have been separate from performance measurement efforts in general healthcare. Good care for behavioral healthcare problems must involve both general and specialty behavioral healthcare providers. The workshop assessed the current state of healthcare performance measurement for patients with mental illness and substance use disorders and recommended promising measurement areas for consideration in current NQF projects.
Published May 2005

Child Health Quality Measurement and Reporting—Workshop
To date, there are relatively few NQF-endorsed™ performance measures that address the care settings, health conditions, and/or healthcare needs of particular importance to children. Supported in part by the March of Dimes and the National Association of Children's Hospitals and Related Institutions, the Workshop explored 1) which aspects of children's healthcare are especially good targets for quality measurement and improvement; 2) for which of these areas can fully developed performance measures be identified; 3) of the identified areas, which are likely to be the most promising targets for NQF consensus efforts, and why; and 4) what actions can and should be taken to enable future consensus on and implementation of performance measures in other important areas of children's healthcare? **Published July 2004**

Hospital Governing Boards and Quality of Care: A Call to Responsibility
It is well established that hospital governing boards (e.g., boards of trustees) have responsibility for the quality of care provided in the institutions they govern. However, hospital boards have been generally viewed as being rather passive in their approach to quality improvement, leaving this responsibility to the medical staff or delegating it to a quality committee of the board. As follow-up to a March 2004 meeting, a "Call to Responsibility" was developed that calls on hospital governing boards to review their policies and practices to make sure that they are consistent with four principles fundamental to delivering quality healthcare. **Proceedings available online**

Information Management and Healthcare Quality—A National Summit
NQF convened, along with the Institute of Medicine, a National Summit on Information Technology and Healthcare Quality in March 2002. This program focused on 1) the state of the nation's health information infrastructure; 2) barriers to achieving the timely flow of necessary health information across the continuum of care; and 3) actions needed to adopt the laws, standards, business practices and technologies necessary to create a state-of-the-art national health information infrastructure. **Published December 2003**

Improving Healthcare Quality for Minority Patients—Proceedings of a Workshop
The need to assess healthcare quality metrics specific to minority populations is particularly acute because of the significant disparities that persist in health and healthcare outcomes for minority populations in the United States. In June 2001, the NQF commissioned papers and convened a group of experts to address 1) whether there are or should be measures to assess the quality of healthcare specifically for minority populations; 2) whether existing measures of healthcare quality are adequate for minority populations; and 3) whether collecting and reporting healthcare quality data related to minority populations raise unique challenges. **Published June 2002**

Improving Patient Safety through Informed Consent for Patients with Limited Health Literacy
This project investigated the barriers to, and strategies for, successfully implementing the NQF-endorsed™ Safe Practice #10, "ask each patient or legal surrogate to recount what he or she has been told during the informed consent discussion," with particular emphasis on providers serving large limited English proficiency and low-literacy populations. The report presents the evaluation of the experiences of early adopters of the practice and results of deliberations on these case studies at a workshop convened by NQF. Additionally, a "user's guide" of practical suggestions was prepared for providers and plans that wish to improve patient safety by implementing this practice. **Published September 2005**

Pay-for-Performance Programs: Guiding Principles and Design Strategies—A National Summit
Currently, the prevailing methods of paying for healthcare in the United States neither incent nor reward providing high-quality care. The soaring costs of healthcare, coupled with an increasing knowledge of the extent of poor-quality care, have made clear the need for a major transformation of the way that healthcare is financed in this country. Based in large part on a national summit to be convened on March 1-2, 2005, this project assessed the various types and prevalence of healthcare initiatives in which payment is used as a mechanism to incent or reward higher quality of care—so-called "pay-for-performance" programs—and determined what design principles or other characteristics of these programs are known to produce the desired outcome. The conference also examined what things are associated with a lack of success and identify the current major gaps in knowledge regarding pay-for-performance. **Published October 2005**

State-of-the-art in Performance Review Instruments—Workshop
A comprehensive quality/performance review program is a management tool used by healthcare systems to aggregate and quantify the various aspects of hospital care to enable comparisons of performance. These programs may include a variety of domains, such as external review (e.g., Joint Commission survey results), patient safety, liability/risk management, satisfaction (customer, patient, employee, provider), financial performance, efficiency, and personnel development. Successful hospital performance reporting instruments used by management could be modified for use as a consumer tools to quantifiably compare hospitals in the United States. This project commissioned a paper to review current knowledge about the broad hospital quality/ performance reporting tools, which was discussed by workshop participants with an eye toward recommending the domains that these tools should encompass, as well as data categories or elements and reporting formats. This project was not a consensus development project; the workshop was funded, in part, by HCA and the Department of Veterans Affairs. **Proceedings available online**

Evidence-based Substance Abuse Treatment Practices—Workshop
Over the past 15 years, scientific knowledge of effective, evidence-based therapies to treat substance use disorders has increased substantially. As with other aspects of healthcare, the increase in scientific knowledge has not necessarily been accompanied by consistent implementation of proven methods of treatment.

On December 13, 2004, NQF convened a workshop to 1) identify a specific set of evidence-based treatments for substance use disorders that are widely recognized as being important components of effective treatment programs; 2) agree upon the essential components and attributes of a substance abuse treatment program that employs these practices, some of which may be generic to all treatment for any substance abuse problem and others specific to the treatment for abuse of particular substances; and 3) recommend a set of program-level descriptors relating to those attributes that indicate that evidence-based substance abuse treatments are being provided by the program to its clients; and recommend possible steps toward a full consensus project. **Proceedings available online**

Reaching the Tipping Point: Measuring and Reporting Quality Using the NQF-Endorsed™ Hospital Care Measures—Proceedings of a National Summit
Together with the National Health Care Purchasing Institute (NHCPI) and support from the Robert Wood Johnson Foundation, NQF convened an invitation-only workshop of hospital decision makers, purchasers, and consumers to address the question, "What would be required to get the NQF-endorsed™ performance measures implemented and the results disclosed?" The meeting was held in February 2003 at the historic Wye River Conference Center in Queenstown, Maryland. **Published September 2003**

Other Completed Projects:

Compendium 2000-2005
In 1998, a Presidential Commission recommended the creation of a national forum in which healthcare's many stakeholders could, together, find ways to improve the quality and safety of American healthcare. This recommendation led to the creation of NQF, a private, not-for-profit, public benefit corporation established in 1999 to standardize healthcare quality measurement and reporting. Just 6 years later, NQF has endorsed more than 200 consensus standards. For the first time, all NQF-endorsed™ consensus standards have been collected in an easy-to-use sourcebook in both print and electronic formats. **Published May 2006**

Improving Patient Safety in Medication Use—Special Emphasis for Limited English Proficiency (LEP) and Low Literacy Populations
Patients' compliance with medication use is a significant problem that can lead to short- or long-term disability or death. This report 1) assessed the state of evidence supporting practices to improve medication compliance for all U.S. healthcare consumers, in particular LEP/low-literacy populations; 2) presented a broad framework for identifying and implementing a set of practices to improve medication compliance on a national scale, with a particular focus on LEP/low-literacy populations; and 3) reported on recommendations from an NQF workshop on how to broadly improve medication compliance, generally, but in particular for LEP/low-literacy populations. **Published October 2005**

Implementing National Voluntary Consensus Standards for Informed Consent: A User's Guide for Healthcare Professionals
As part of the project, *Improving Patient Safety through Informed Consent for Patients with Limited Health Literacy,* NQF produced this publication to assist organizations with implementation of Safe Practice 10. The guide, based on interviews and site visits with facilities that had adopted Safe Practice 10 and those that had not, also includes an online resources guide. **Available online**

Consumer-Focused Measures of Mammography Center Quality
Mammography is a service that is widely used and for which consumers often have a choice of providers, as well as considerable interest in quality of care. This project will identify candidate measures of mammography center quality; assess the technical validity and scientific importance of consumer recommended measures; assess the feasibility of collecting the data needed to calculate new measures considered meaningful to consumers; and synthesize the findings of the activities above and propose a final set of candidate measures for future testing in public reports. **Manuscript available online**

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