THE NATIONAL QUALITY FORUM

ANNUAL MEETING 2004

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ABSTRACT

PURPOSE: The theme of the National Quality Forum's 5th Annual Meeting was "Improving Healthcare Quality for All Americans: Fulfilling the Healthcare Quality Imperative through Innovation and Implementation." The meeting was a venue to foster dialogue among its members, provide updates on NQF activities, focus on the implementation of national voluntary consensus standards for healthcare quality, learn about federal initiatives to drive healthcare quality improvement, and recognize outstanding contributions to patient safety and quality improvements.

SCOPE: More than 250 individuals from 151 organizations attended the meeting. The sessions dealt with issues that ranged from implementation examples and strategies at local facilities to documenting and examining the movement toward national healthcare quality improvement. The sessions engaged all stakeholders and helped develop a shared understanding of the interconnected roles of regulators, accreditors, and health professional educators in supporting national healthcare quality improvement.

METHODS: The format of the meeting included a mix of four types of meetings: plenary, inter-council, and breakout sessions and the NQF Board of Directors meeting.

RESULTS: Participant evaluation and feedback was positive; however, suggestions were made to extend future meetings and provide more time for inter and intra-Council discussions. The major products resulting from the meeting were set of implementation recommendations and a document summarizing the state-of-implementation in the healthcare domain. An overview paper that included a summary of the results of the breakout sessions was also produced.

KEY WORDS: National Quality Forum, Annual Meeting, Healthcare Quality

PURPOSE: The theme of the National Quality Forum's 5th Annual Meeting was "Improving Healthcare Quality for All Americans: Fulfilling the Healthcare Quality Imperative through Innovation and Implementation." The meeting was a venue to foster dialogue among its members, provide updates on NQF activities, focus on the implementation of national voluntary consensus standards for healthcare quality, learn about federal initiatives to drive healthcare quality improvement, and recognize outstanding contributions to patient safety and quality improvements.

By focusing on existing healthcare quality improvement initiatives and innovative implementation strategies undertaken to improve the quality of care and practice, the 5th NQF Annual Meeting brought together members and other interested parties to:

- Provide insights on strategies that the NQF might pursue to facilitate implementation of quality measures;
- Hear case studies about implementation efforts of NQF member organizations and others;
- Learn about efforts that should, in both the short and long terms, make it easier for healthcare providers and others to collect, verify and report performance data;
- Learn from policymakers what additional actions and/or steps should be taken to stimulate, catalyze, or otherwise facilitate implementation of NQF-endorsed measures;
- Continue to document healthcare's steady progress toward a national quality measurement and reporting system; and
- Generate a sense of commitment on the part of each stakeholder towards quality and an understanding of what the healthcare quality imperative is.

Although also a theme of the last annual meeting, it is clear that implementation continues to occupy center stage for the NQF members. In fact, with the number of measure sets increasing, both the importance and challenge of broad implementation of the measures become even more critical.

SCOPE: The NQF is a not-for-profit open membership public benefit corporation whose 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. The NQF's 5th Annual Meeting was held October 6-7, 2004, at the Four Seasons in Washington, DC. The meeting, "Improving Healthcare Quality for All Americans: Fulfilling the Healthcare Quality Imperative through Innovation and Implementation," focused on the implementation of national voluntary consensus standards for healthcare quality.

The NQF's member organizations represent the total spectrum of healthcare stakeholders, categorized within four NQF Member Councils. The members work collaboratively to promote a common approach to measuring healthcare quality, including the endorsement and implementation of voluntary consensus standards.

More than 250 individuals from 151 organizations attended the meeting. The meeting included participants from both the public and private sectors including representatives from all four NQF Councils. (See Appendix A for a list of NQF members and Appendix B for the meeting agenda.)

METHODS: As in past years the format of the meeting included a mix of four types of meetings:

- Plenary sessions, presenting overviews of topics related to quality measurement and improvement;
- Concurrent Inter-Council Sessions;
- Breakout sessions which included open discussions of NQF policies, implementation and use of NQF consensus measure sets; and
- Meeting of the NQF Board of Directors.

RESULTS:

October 6, 2004: Opening Plenary Session

On the morning of October 6, 2004, Dr. Kenneth W. Kizer, President and Chief Executive Officer of the NQF, welcomed participants to NQF's 5th Annual Meeting. In giving an overview of the day's objectives, Dr. Kizer indicated that the meeting was organized to allow ample time for members to discuss the role of member implementation of NQF-endorsed voluntary consensus standards as well as members' own quality improvement activities. The NQF has spent considerable effort over the past 5 years conceptualizing and implementing a quality measurement and reporting system. Members of the Forum also recognize that healthcare improvement is grounded in the willingness of the membership to use indicators of healthcare quality and disclose the results. The NQF's 5th Annual Meeting was an opportunity to continue a dialogue that will lead to the coordinated implementation of NQF-endorsed voluntary consensus standards.

October 6, 2004: Case Study/Innovation Panel 1
Participants: Nancy Foster, Treacy Colbert, and Richard Lofgren
Moderator: Steve Wetzell

By identifying areas in which consensus is really needed, this panel provoked discussions among NQF members about the opportunities for potential expansion of the NQF work on future measures to reduce redundant data processing while improving the opportunity to make reliable information available as well as innovative collaborations and incentives for improving healthcare quality.

> **Nancy Foster, American Hospital Association, From Consensus Measures to Consensus.** The Hospital Quality Initiative is the national voluntary reporting initiative designed to make hospital quality information available to the public. The Initiative relies on the National Quality Forum's set of core hospital measures. The first 10 measures that constitute the starting point for the Initiative, and the next dozen measures that are being added to the Initiative will also come from the NQF measure set. The organizations that have partnered to create the Initiative have agreed that only measures that have come through the NQF's consensus process and that are appropriate for assessing inpatient care will be used. This means that the Initiative partners are eager for the NQF to consider additional appropriate measures of hospital care, such as HCAHPS, and measures of other clinical conditions. NQF Members heard about the additional work that had to be done to achieve alignment of the data collection for the starter set of 10 measures to ensure that hospitals could collect the data once and use it to fulfill the voluntary public reporting requirements, reporting to The Joint Commission for purposes of accreditation, and participation in quality improvement activities, such as the 7th Statement of Work with the Quality Improvement Organizations (QIOs). The NQF consensus measures provided a starting point for the data collection, but it was only a starting point. Much more is needed to be done. This presentation focused on the lessons learned about the need for consensus and alignment in data collection and disclosure of the information. It described the level of agreement that actually must be achieved if the burden of collecting data is to be minimized and the value of the information collected is to be maximized.

The presentation identified aspects of the measures and measurement process on which there needs to be consensus, including instructions for data collection, sampling methods, and data display methods.

Treacy Colbert, California Health Decisions, Healthy Incentive: Rewarding Health, Improving Outcomes, Increasing Satisfaction. Healthy Incentive is a bold initiative to improve health quality by offering cash incentives to patients who achieve targeted health benchmarks and/or complete key screenings. This presentation described Healthy Incentive - its background, philosophy, structure, and goals. Attendees heard how Healthy Incentive rewrote the contract between patient and physician, changing their relationship by engaging both in a team effort based on shared capabilities and goals. Healthy Incentive replaces traditional methods of motivating consumers that have met with limited success, such as health club discounts or free transportation to physician appointments, and offers a simple and straightforward reward for certain healthy behaviors. In addition, the presentation defined the positive interaction between Healthy Incentive and the Pay for Performance initiative, where patients and physicians are aligned around mutual objectives and the potential for monetary compensation. Those who attended this presentation left with a fresh perspective on changing patient behavior and improving outcomes through a consumer-driven, practical, sometimes controversial, new program.

Richard Lofgren, MD, MPH, Medical College of Wisconsin, Physician Leadership in Performance Reporting. In healthcare, voluntary disclosure of outcome data can add and create credibility, a sense of integrity, and an urgency to improve, both internally and externally. This was the philosophy around which nine physician-led healthcare organizations and their employer-partners rallied in October 2002 to form the Wisconsin Collaborative for Healthcare Quality (the Collaborative). They set out to prove that seven hospitals, six multi-specialty physician groups, four health plans, and nine employer-partners from across the state could agree upon the mutually beneficial goal of increased transparency and work collaboratively to achieve it. Together, they produced the first Performance and Progress Report, released in one year's time. Based on a desire to improve the quality of healthcare throughout the state, the founders of the Collaborative agreed on shared learning and public accountability as key drivers for continuous quality improvement. They agreed to develop a set of common measures of healthcare quality outcomes and publicly report the performance of their healthcare organizations against those measures.

October 6, 2004: Morning Plenary Session

Mark McClellan, MD, PhD, Administrator of the Centers for Medicare and Medicaid Services provided an update to members on national quality improvement efforts presently underway at the agency and elsewhere in the Department of Health and Human Services (DHHS). DHHS is committed to improving the quality of healthcare for all Americans. Part of realizing this commitment is CMS's effort to empower consumers with quality of care information to make more informed decisions about their healthcare, and stimulate and support providers and clinicians to improve the quality of healthcare. As part of his plenary presentation, he gave an overview of the following CMS initiatives:

- Nursing Home Initiative. On November 12, 2002, CMS published quality measures for all Medicare and Medicaid-certified Nursing Homes.
- Home Health Initiative. On May 1, 2003, CMS launched Phase 1 of the Home Health Quality Initiative with the publication of home health quality measures for eight states.

- Hospital Initiative. CMS has several efforts in progress to provide hospital quality information to consumers and others and to improve the care provided by the nation's hospitals.

October 6, 2004: Case Study/Innovation Panel 2
Participants: Marie Dotseth, Hedy Cohen, RN, Mary Reich Cooper, MD, JD, Martin S. Levine, DO.
Moderator: Daniel B. Wolfson

Marie Dotseth, Minnesota Department of Health, Minnesota's Adverse Events Reporting System: Implementing the NQF's 27 Serious Reportable Events. In 2003, Minnesota became the first state to fully adopt the NQF medical errors reporting standards when the Minnesota Legislature enacted and the governor signed the Adverse Health Events Reporting Law. This initiative had broad support from the healthcare community, including the Minnesota Hospital Association (MHA) and Minnesota Department of Health (MDH). A preliminary system for reporting these events has been developed by the MHA), and event reports from hospitals are now being provided directly to the MHA. Upon full implementation of the law, the MDH will receive event reports directly from hospitals. In light of the many related state and federal regulations concerning adverse health events, the MDH is working with hospitals, providers, purchasers, and consumers to clarify and address questions and to move toward full implementation of the law as quickly as possible. Numerous lessons have been learned in the startup efforts under this new law. These lessons include the need to protect reported data from disclosure; provide a clear understanding of how state and federal regulatory requirements interface with adverse event reporting laws; identify ongoing sources of funding for patient safety initiatives; continually work together to clarify reportable events to ensure consistent; and, through reporting, have strong leadership so that trust and patience develop among all parties.

Hedy Cohen, Institute for Safe Medication Practices, The Value of a Safety Self-Assessment Tool to Stimulate Organizational Practice Change. In the spring of 2004 the Institute for Safe Medication Practices (ISMP), in partnership with the American Hospital Association (AHA) and the Health Research & Educational Trust (HRET), released a medication safety self-assessment tool to all hospitals in the U.S. Conducted for the first time in 2000, the assessment allowed hospitals to gauge their activities in nearly 200 characteristics and core practices, which have most significantly influenced safe medication use and to also identify challenges and opportunities for change. The 2004 assessment helped participating hospitals measure their progress toward patient safety over the past 4 years and allow for all respondents to compare their current medication-use system and organizational practices to other demographically similar hospitals nationwide. The presentation examined how ISMP and its partners used results from the 2000 assessment to identify problem areas, which eventually led to the development of Pathways for Medication Safety, a series of three educational programs: Leading a Strategic Planning Effort, Looking Collectively at Risk, and Assessing Bedside Bar-Coding Readiness. ISMP's goal was to compare the aggregate data from the 2000 and 2004 surveys to evaluate our nation's total progress in medication-use safety over the past 4 years, which reflected whether healthcare organizations have made improvements in patient safety. These results helped ISMP and its partners plan new curricula and other means of support to assist organizations to improve their medication-use process. The final objective of this presentation was to demonstrate the value of data collection about existing practices as a first step in accurately identifying current gaps in patient safety and to use this information to support the design of effective models and innovative tools to ensure that every patient receives safe, quality care.

May Reich Cooper, New York Presbyterian, SUMORS: Standardizing Use of Medication in the Operating Rooms. Unlike other areas of the hospital, medication errors in the operating room occur infrequently, but when they do happen they are often catastrophic. In 1995, a seven-year old boy died due to a medication mix-up in which he was inadvertently injected with epinephrine 1:1,000 (1 mg) instead of lidocaine 1% with epinephrine 1:100,000 (0.01 mg) at the inception of a routine surgical procedure. Both medications were poured from their labeled containers into sterile bowls on the surgical field when the mix-up occurred. The settlement agreement required the hospital to teach others about the possibility of errors from the sterile field, and the case was featured on Dateline in Spring 2003. Beginning August 2003, New York-Presbyterian Hospital studied the probability of error on the sterile field and there were many findings to report. Many established medication safety practices have yet to be adopted in operating rooms. The medication use process (procurement, ordering, dispensing, administration, monitoring) in the intraoperative setting is complex, thereby increasing the likelihood for medical error. Anesthesiology has studied medical errors, but no one has studied the sterile field in the operating rooms with the same rigor. The use of multiple medications and non-standard concentrations, the lack of a defined labeling system, the common practice of verbal orders, and the absence of patient unit-dosing provide opportunity for the reduction of medication errors in operating rooms.

Martin Levine, DO, American Osteopathic Association, Update on the AOA's Clinical Assessment Program. The American Osteopathic Association's Clinical Assessment Program (CAP) measures current clinical practices in osteopathic residency programs for quality improvement. The goal of CAP is to improve patient outcomes by providing valid and reliable assessments of current clinical practices. The CAP measures include Diabetes Mellitus, Coronary Artery Disease, Women's Health Screening, Childhood Immunizations, Adult Immunizations, Hypertension, and Low Back Pain. At the end of academic year 2003-2004, 54 family practice and three internal medicine residency programs have submitted data to the CAP database reporting on 3,386 patients. CAP has provided each participating residency program a near real-time report of current clinical practices (14 days following the close of data collection). The initial performance score for each clinical indicator established a benchmark whereby residencies can compare progress in future studies, compare performance to national standards and compare their performance to other residency programs.

October 6, 2004: Afternoon Plenary Session/The Information Technology Imperative

David J. Brailer, MD, PhD, Office of the National Coordinator for Health Information Technology, National Coordinator for Health Information Technology. Dr. Brailer gave his views on the information technology imperative. Since Dr. Brailer was appointed the first National Health Information Technology Coordinator, he has emphasized that improved diffusion of technology will greatly accelerate healthcare quality improvements. Dr. Brailer's role is to support and drive widespread deployment of health information technology within 10 years to help realize substantial improvements in safety and efficiency. Dr. Brailer is recognized as a leader in the strategy and financing of quality and efficiency in healthcare, with a particular emphasis on health information technology and health systems management. Dr. Brailer provided an overview of the near-term goals of the Office of the National Health Information Technology Coordinator including that HHS and other federal agencies will adopt 15 additional standards agreed to by the Consolidated Health Informatics (CHI) initiative to allow for the electronic exchange of clinical health information across the federal government.

The medical vocabulary known as SNOMED CT[1] is a key clinical language standard needed for such a national health information infrastructure. Establishing nationwide guidelines for electronic health records is another goal.

October 6, 2004: Afternoon Plenary Session/The National Healthcare Quality and Disparities Reports

Carolyn Clancy, MD, Director, Agency for Healthcare Research and Quality. Dr. Clancy presented a speech entitled 'From Measurement to Action' and began by providing an overview of the National Healthcare Quality Report and National Healthcare Disparities Report. The former report represents the first national comprehensive effort to measure the quality of healthcare in the United States, whereas the latter is the first national effort to measure differences in access and use of healthcare services by various populations. The work represents the first time that healthcare policymakers and others have been provided with information to assess existing healthcare quality improvement efforts and represents a roadmap to guide future efforts to improve quality. AHRQ remains committed to its role as the national leader in accurately measuring outcomes, community access to care, utilization, and costs. In her presentation, Dr. Clancy described the various healthcare decision making and research tools developed by AHRQ that can be used by program managers, researchers, and others at the federal, state and local levels to assess the care delivered and improve the quality of care for all Americans.

October 6, 2004: Case Study/Innovation Panel 2
Participants: Barbara A. Rudolph, PhD, Thomas A. Wilson, RN, Donna Isgett
Moderator: Donald E. Casey, Jr., MD, MPH, MBA

Barbara Rudolph, The Leapfrog Group, Implementing NQF-Endorsed Safe Practices. The case study outlined how The Leapfrog Group took the NQF-endorsed Safe Practices, weighted them, formulated survey questions, and implemented them as Leapfrog's fourth 'leap' in the annual hospital quality and safety survey ('the Leapfrog survey'). The Leapfrog's objective was to turn the NQF-endorsed safe practices into a rolled-up measure to be fielded in the Leapfrog online survey as a means of measuring hospital safety and quality performance. The survey provided data for inter-hospital benchmarking, information for consumers to help them make informed healthcare choices and data for incentive and rewards programs. The presentation explained how the Leapfrog team went about translating the NQF-endorsed Safe Practices into survey questions. This was fielded to 1,262 hospitals using Leapfrog's network of 23 Regional Roll Outs. The online data were updated every month. The barriers and challenges that arose during the survey development included issues around scoring, keeping the survey to a manageable length, overcoming hospital resistance and the ambitious timescale for development and implementation.

Thomas Wilson, MD, Yale-New Haven Health System, Yale-New Haven Health System's Implementation of NQF-Endorsed Voluntary Consensus Standards. Yale-New Haven Health System is a three-hospital health system in southern Connecticut and a National Quality Forum member since 2001. Their mission, to provide outstanding, high-quality, safe care for all patients, called them to implement NQF voluntary consensus standards for hospital performance measurement and safe practices. The three Yale-New Haven Health System member hospitals have worked together to set quality and safety priorities, through the YNHHS Quality Council

[1] SNOMED Clinical Terms® stands for the Systematized Nomenclature of Medicine. SNOMED CT is a dynamic, scientifically validated clinical reference terminology that makes healthcare knowledge more usable and accessible. The SNOMED CT Core terminology provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care. Among the applications for SNOMED CT are electronic medical records, ICU monitoring, clinical decision support, medical research studies, clinical trials, computerized physician order entry, disease surveillance, image indexing and consumer health information services.

and Senior Executive Group, and foster accountability, through the YNHHS Performance Management Initiative. A number of the NQF standards have been incorporated into their "executive dashboard," available to managers on the YNHHS intranet, and more are planned. This has helped to enable improvement, through adoption of Six Sigma improvement methods throughout their organization. As of the end of FY 2004, they had incorporated into their work and business plan 30 of 39 NQF National Voluntary Consensus Standards for Hospital Care, and the other nine standards are planned for adoption during FY 2005. Of the 30 NQF-Endorsed Set of Safe Practices, they had fully adopted 16, had made significant progress toward full adoption for four, had begun to address six, and had not yet addressed four. YNHHS had identified factors that sped implementation of standards: strength of the evidence base supporting the standard; applicability of the standard to an organization-wide approach; and congruence of the standards with other national organizations' quality and safety goals. Accountability for achieving these standards was fostered through incorporation into their business plans, and through a YNHHS-wide approach to measurement and reporting about progress, including their "executive dashboard."

Donna Isgett, Premier, Achieving Success in the CMS/Premier Hospital Quality Incentive Demonstration Project: A Participant's Story. In July 2003, Premier and the Centers for Medicare and Medicaid Services (CMS) launched the Hospital Quality Incentive Demonstration Project, a three-year program designed to determine if economic incentives are effective in improving the quality of inpatient care. The 278 hospitals participating in the demonstration project were eligible for increased Medicare payments in five clinical areas if they were among the top performers in a given area. The clinical areas are: heart attack, coronary artery bypass graft, heart failure, community-acquired pneumonia, and hip and knee replacement. In this demonstration, CMS measured and paid incentives for high quality inpatient care. One of the participating hospitals, McLeod Regional Medical Center in Florence, SC, gained national attention for instituting a clinical effectiveness program. This program was intended to produce major breakthroughs in clinical outcomes, patient satisfaction, and reduction in expenses. An important component of this physician-driven approach used comparative data from Clinical Advisor as the foundation for the evidence-based methodology from which all focused improvement activities grew. The Clinical Advisor solution provided the assessment, data, and evidence-based information that allowed hospitals to measure outcomes in quality and cost, track performance improvements and benchmark against others.

John M. Eisenberg Patient Safety and Quality Award Presentation

The National Quality Forum and The Joint Commission on Accreditation of Healthcare Organizations awarded the 2004 John M. Eisenberg Patient Safety and Quality Awards. This year's recipients were selected in each of the four award categories. The honorees, by award category, were:

Individual Achievement - Lucian Leape, MD, of the Harvard School of Public Health, Boston, MA, for his fundamental conceptual contributions to contemporary understanding of the nature of medical errors and the extent of the patient safety problem and for his tireless efforts to improve the safety of care for all patients.

Research Achievement - Peter Pronovost, MD, PhD, of The Johns Hopkins University School of Medicine, Baltimore, MD, for his creative research initiatives that have led to dramatic improvements in the safety and quality of care in intensive care units.

Innovation in Patient Safety and Quality at a National or Regional Level (2 winners) - Kaveh G. Shojania, MD, and Robert M. Wachter, MD of the University of California at San Francisco, San Francisco, CA, for

the creation of a highly successful case-based approach to educating practitioners, provider organization leaders, policymakers, and patients about patient safety issues—through the professional literature, the world wide web, and a best-selling nonfiction book; and Major Danny Jaghab of Brooke Army Medical Center, San Antonio, TX, for the creation of a distance learning program — now available through the U.S. Department of Defense —that provided education about sentinel events, root cause analyses, risk-reduction strategies, and policies and recommendations associated with The Joint Commission's National Patient Safety Goals.

Innovation in Patient Safety and Quality at a Local or Organization Level - University of Pittsburgh Medical Center —McKeesport, McKeesport, PA, for development of personalized patient safety self-learning packets that have demonstrated their effectiveness in creating an organization culture of patient safety that facilitates the resolution of problems associated with hospital-acquired infections and falls.

October 7, 2004: Member Council Meetings

Each member organization of the NQF belongs to one of four NQF Member Councils: Consumer, Purchaser, Provider/Health Plan, and Research and Quality Improvement.

Sessions were primarily business and content meetings that focused on ongoing discussion of NQF projects, NQF and Council operations, and the implementation of NQF measure sets.

October 7, 2004: Board of Directors Meeting

Dr. Kizer began by welcoming those assembled for the open session of the NQF Board of Directors meeting and launched into a lively discussion of Home Health Performance Standards and Cardiac Surgery Performance Measures. During the meeting, the Board also discussed matters related to Board turnover and creation of the Technology Council, which passed the Board by significant margins but for which a few Board members asked for additional discussion. New project funding came from several sources. NQF concluded negotiations with the Delmarva Foundation (the prime contractor to CMS) for three tasks: Endorsement of HCAHPS, endorsement of performance measures in additional hospital quality measures and convening of a pay-for-performance summit. Dr. Kizer then presented a number of project updates, including:

Serious Reportable Adverse Events in Healthcare. Connecticut recently enacted legislation to make this list of adverse events mandatory reporting events at the state level. Additionally, Saskatchewan, Canada, recently enacted a law to collect data at the province level based largely on NQF's list of serious reportable events. New Jersey and Maryland also have contacted NQF staff about incorporating the NQF-endorsed events into their systems. Texas has adopted the list, in part.

Voluntary Consensus Standards for Adult Diabetes Care: Update. NQF anticipates updated specifications as part of the ambulatory-DOQ measure set. Once specifications are received, NQF will conduct a second 30-day review of the updated measures with their detailed specifications.

Safe Practices for Better Healthcare. The Leapfrog Group web site now reports results from its "fourth leap," a survey that incorporates the 27 NQF safe practices that were not previously part of its initiative. (The first three leaps are for three of the NQF-endorsed safe practices.)

National Voluntary Consensus Standards for Hospital Care (including new areas and HCAHPS). Ten of the endorsed measures are now being publicly reported on the CMS website as part of a voluntary hospital reporting initiative; these 10 measures must be reported for facilities to receive maximum payment from the government under the MMA.

In 2005, an additional 12 measures from the NQF-endorsed set will be added to the voluntary reporting initiative, along with HCAHPS. CMS has provided funding for HCAHPS and new consensus standards in three additional hospital areas. The areas to be addressed have yet to be finalized. The Catholic Health Association of the U.S. (CHA) has written and formally requested to work with NQF on implementing all of the hospital measures. CHA is the first hospital organization to formally commit to implementing all the NQF-endorsed hospital measures.

Ambulatory Care Quality Measures. More than 100 NQF members from 53 organizations participated in workgroup meetings in Boston on April 27 and identified 10 priority areas. Related to this project, CMS has asked NQF to consider its Doctor Office Quality (DOQ) measures under expedited consensus. RWJF also has asked NQF to prepare a proposal for phase II—endorsement of measures—in the 10 priority areas and a roll-up index. As agreed to at the April 2004 meeting, the DOQ measures will initially proceed through expedited consensus, but they will be re-evaluated under full consensus (with a call for measures) during phase III.

ACEIs vs ARBs Performance Measure Resolution Workshop. In 2002, NQF endorsed two measures (developed jointly by The Joint Commission and CMS), addressing use of angiotensin converting enzyme inhibitor (ACEI) 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. This workshop, which is co-sponsored with AHRQ, will examine 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 as well as use of ACEIs.

Evaluation of the Conference

Conference participants were provided with an evaluation form in which they could quantitatively rate the various aspects of the conference. In addition, the form invited open-ended comments. Both the content and format for the conference received an overall favorable rating from members and nonmembers in attendance. Comments included:

- I would like to see more organizations discuss their implementations of the NQF endorsed products. Thus far, there is no one-stop place to see those that are putting these endorsed products into action.
- Would be interested to see more on the relationship between IT adoption and measurement adoption.
- Would suggest future programming on making the business case for quality. What are potential methodologies? Also, what are leveraging tools for developing an organizational culture for safety and improvement and is there potential for discussion about the avenues to change culture.
- Intercouncil discussions are very valuable; please provide more time for council and intercouncil discussions.
- Would like to see presentations further highlighting the role of ancillary services, such as nursing, respiratory therapy, and pharmacy, in implementing and maintaining quality improvement initiatives.
- A study of nursing education (BSN, MS, etc.) as it relates to quality of patient care. NQF is becoming a standard for healthcare quality and reporting. It is an important organization for others to follow.
- Look for opportunities to further highlight issues of state regulatory setting of performance versus consensus based standards. Would like to see additional presentations on providers' proceeding/succeeding to take on performance standards.

THE NATIONAL QUALITY FORUM

Members

CONSUMER COUNCIL

AARP
AFL-CIO
AFT Healthcare
American Hospice Foundation
California Health Decisions
Consumers Advancing Patient Safety
Consumers' Checkbook
Consumer Coalition for Quality Health Care
March of Dimes
National Citizens' Coalition for Nursing Home Reform
National Coalition for Cancer Survivorship
National Family Caregivers Association
National Partnership for Women and Families
Service Employees International Union

PURCHASER COUNCIL

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Centers for Medicare & Medicaid Services
Central Florida Health Care Coalition
District of Columbia Department of Health
Employers' Coalition on Health
Employer Health Care Alliance Cooperative (The Alliance)
Ford Motor Company
General Motors
Greater Detroit Area Health Council
HealthCare 21
Leapfrog Group
Maine Health Management Coalition
Midwest Business Group on Health
National Association of State Medicaid Directors
National Business Coalition on Health
National Business Group on Health
Pacific Business Group on Health
Schaller Anderson
South Central Michigan Health Alliance
US Office of Personnel Management
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RESEARCH AND QUALITY IMPROVEMENT COUNCIL

AAAHC-Institute for Quality Improvement
ACS/MIDAS+
AI Insight
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American Association of Colleges of Nursing
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American Board of Internal Medicine Foundation
American Board of Medical Specialties
ACC/AHA Taskforce on Performance Measures
American College of Medical Quality
American Health Quality Association
American Pharmacists Association Foundation
American Society for Quality-Health Care Division
Anesthesia Patient Safety Foundation
Aspect Medical Systems
Association for Professionals in Infection Control and Epidemiology
Association of American Medical Colleges
Aventis Pharmaceuticals
California HealthCare Foundation
Cancer Quality Council of Ontario
Cardinal Health
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Cleveland Clinic Foundation
Coral Initiative
Council for Affordable Quality Healthcare
CRG Medical
Delmarva Foundation
Dialog Medical
eHealth Initiative
Eli Lilly and Company
First Consulting Group
Florida Initiative for Children's Healthcare Quality
Forum of End Stage Renal Disease Networks
Health Care Excel
Health Grades
Health Resources & Services Admin
Illinois Department of Public Health
Institute for Clinical Systems Improvement
Institute for Safe Medication Practices
Integrated Healthcare Association
Integrated Resources for the Middlesex Area
IPRO
Jefferson Health Sys, Off. of Health Policy and Clinical Outcomes
JCAHO
Long Term Care Institute
Loyola University Health System Ctr for Clinical Effectiveness
Lumetra
Maine Quality Forum
Medical Review of North Carolina
National Academy of State Health Policy
National Association for Healthcare Quality
National Committee for Quality Assurance
National Committee for Quality Health Care
National Consortium of Breast Centers
National Institutes of Health
National Patient Safety Foundation
National Research Corporation
New England Healthcare Assembly
New Jersey Health Care Quality Institute
Northeast Health Care Quality Foundation
Ohio KePRO
OmniCare
Pennsylvania Health Care Cost Containment Council
Pfizer
Physician Consortium for Performance Improvement
Press, Ganey Associates
Professional Research Consultants
ProHealth Care
Qualidigm
Research!America
Roswell Park Cancer Institute
Sanofi-Synthélabo
Select Quality Care
Solucient
Texas Medical Institute of Technology
Uniform Data System for Medical Rehabilitation
United Hospital Fund
University of North Carolina-Program on Health Outcomes
URAC
US Food and Drug Administration
US Pharmacopeia
Virginia Cardiac Surgery Quality Initiative
Virginia Health Quality Center
West Virginia Medical Institute

HEALTH PROVIDER AND HEALTH PLAN COUNCIL

Adventist HealthCare
Aetna
Alexian Brothers Medical Center
Alliance for Quality Nursing Home Care
America's Health Insurance Plans
American Academy of Family Physicians
American Academy of Nursing
American Academy of Orthopaedic Surgeons
American Association of Homes and Services for the Aging
American Association of Nurse Anesthetists
American College of Cardiology
American College of Obstetricians and Gynecologists

American College of Radiology
American College of Surgeons
American Health Care Association
American Heart Association
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 Society for Therapeutic Radiology and Oncology
American Society of Clinical Oncology
American Society of Health-System Pharmacists
Ascension Health
Assoc for Professionals in Infection Control and Epidemiology
Bayhealth Medical Center
Baylor Health Care System
Beacon Health Strategies
Beverly Enterprises
BJC HealthCare
Blue Cross and Blue Shield Association
Blue Cross Blue Shield of Michigan
Bon Secours Health System
Bronson Healthcare Group
Catholic Health Association of the United States
Catholic Health Initiatives
Catholic Healthcare Partners
Centura Health
Child Health Corporation of America
CHRISTUS Health
CIGNA Healthcare
College of American Pathologists
Connecticut Hospital Association
Council of Medical Specialty Societies
Detroit Medical Center
Empire BlueCross/BlueShield
Exempla Healthcare
Federation of American Hospitals
First Health
Florida Hospital Medical Center
Gentiva Health Services
Greater New York Hospital Association
Hackensack University Medical Center
HCA
HealthHelp
Healthcare Leadership Council
HealthPartners
Health Plus
Henry Ford Health System
Hoag Hospital
Horizon Blue Cross and Blue Shield of New Jersey
Hudson Health Plan
Illinois Hospital Association
INTEGRIS Health
John Muir/Mt. Diablo Health System
Kaiser Permanente
KU Med at the University of Kansas Medical Center
Los Angeles County - Department of Health Services
Lutheran Medical Center
Mayo Foundation
MedQuest Associates
Memorial Health University Medical Ctr
Memorial Sloan-Kettering Cancer Center
The Methodist Hospital
National Association of Chain Drug Stores
National Association of Children's Hospitals and Related Institutions
National Association Medical Staff Services
National Association of Public Hospitals and Health Systems
National Consortium of Breast Centers
National Hospice and Palliative Care Organization
National Rural Health Association
Nemours Foundation
New York Presbyterian Hospital and Health System
North Carolina Baptist Hospital
North Shore-Long Island Jewish Health System
North Texas Specialty Physicians
Oakwood Healthcare System
PacifiCare
PacifiCare Behavioral Health
Partners HealthCare
Premier
Robert Wood Johnson University Hospital-Hamilton
Robert Wood Johnson University Hospital–New Brunswick
Sentara Norfolk General Hospital
Sisters of Charity of Leavenworth Health System
Sisters of Mercy Health System
Society of Thoracic Surgeons
Spectrum Health
St. Mary's Hospital Medical Center
St. Vincent Regional Medical Center
State Associations of Addiction Services
State University of New York-College of Optometry
Sutter Health
Tampa General Hospital
Tenet Healthcare
Triad Hospitals
Trinity Health
UnitedHealth Group
University Health System Consortium
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 Pennsylvania Health System
University of Texas-MD Anderson Cancer Center
US Department of Defense-Health Affairs
Vanguard Health Management
Veterans Health Administration
VHA
WellPoint
Yale-New Haven Health System

IMPROVING HEALTHCARE QUALITY FOR ALL AMERICANS

THE NATIONAL QUALITY FORUM
5TH ANNUAL MEETING
OCTOBER 6-7, 2004

NATIONAL QUALITY FORUM

5th Annual Meeting

Innovation and Implementation: Fulfilling the Healthcare Quality Imperative

DRAFT AGENDA

OCTOBER 6. 2004

8:30 Opening remarks
Gail L. Warden, Henry Ford Health System
Kenneth W. Kizer, MD, MPH, National Quality Forum

8:45 Case Study/Innovation Panel 1
Moderator: Steve Wetzell, The Leapfrog Group
Nancy Foster,American Hospital Association, "From Consensus Measures to Consensus"
Treacy Colbert, California Health Decisions, "Healthy Incentive: Rewarding Health, Improving Outcomes, Increasing Satisfaction"
Rick Lofgren, MD, MPH, Medical College of Wisconsin, "Physician Leadership in Performance Reporting"
Q&A

10:00 Plenary Speaker: Mark McClellan, MD, PhD, Administrator, Centers for Medicare and Medicaid Services

10:30 Break

10:45 Case Study/Innovation Panel 2
Moderator: Daniel Wolfson, ABIM Foundation
Marie Dotseth, Minnesota Department of Health, "Minnesota's Adverse Events Reporting System: Implementing the NQF's 27 Serious Reportable Events"
Hedy Cohen, RN, Institute for Safe Medication Practices, "The Value of a Safety Self-Assessment Tool to Stimulate Organizational Practice Change"
Mary Reich Cooper, MD, JD, New York Presbyterian, "SUMORS: Standardizing Use of Medication in the Operating Rooms"
Martin S. Levine, DO, American Osteopathic Association, "Update on the AOA's Clinical Assessment Program"
Q&A

12:30 Lunch (Member Council Break-outs)
Consumer Council
Provider/Health Plan Council
Purchaser Council
Research/Quality Improvement Council

1:30 The Information Technology Imperative
David Brailer, MD, PhD, National Health Information Technology Coordinator, U.S. Dept. of Health and Human Services

2:15 From Measurement to Action: The National Healthcare Quality and Disparities Reports
Carolyn Clancy, MD, Director, Agency for Healthcare Research and Quality

NATIONAL QUALITY FORUM

5th Annual Meeting

Innovation and Implementation: Fulfilling the Healthcare Quality Imperative

DRAFT AGENDA

OCTOBER 6, 2004 (Continued)

2:55 Case Study/Innovation Panel 3

Moderator: Donald Casey, MD, MPH, MBA, Catholic Health Partners

Barbara Rudolph, PhD, The Leapfrog Group, "Implementing NQF-Endorsed Safe Practices-The Leapfrog Group Hospital Quality and Safety Survey"

Thomas A. Wilson, RN, MS,Yale-New Haven Health System, "Yale-New Haven Health System's Implementation of NQF-Endorsed Voluntary Consensus Standards"

Stephanie Alexander, McLeod Regional Medical Center/Premier, "Achieving Success in the CMS/Premier Hospital Quality Incentive Demonstration Project: A Participant's Story"

Q&A

4:10 Break

4:25 Presentation of the John M. Eisenberg Patient Safety and Quality Awards

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

Kenneth W. Kizer, MD, MPH, National Quality Forum

Individual Achievement: *Lucian L. Leape, MD*

Research Achievement: *Peter J. Pronovost, MD, PhD*

Innovation in Patient Safety and Quality-National: *Major Danny Jaghab, Brooke Army Medical Center*

Innovation in Patient Safety and Quality-National: *Kaveh G. Shojania, MD and Robert M. Wachter, MD*

Innovation in Patient Safety and Quality-Local: *University of Pittsburgh Medical Center-McKeesport*

4:55 Closing remarks

Gail L. Warden, Henry Ford Health System

5:00 Reception Honoring Recipients of the Eisenberg Awards

OCTOBER 7. 2004

8:30 Member Council/InterCouncil Sessions—**Members Only**

11:45 Board of Directors—Open Meeting

General Business

Member Council Reports

3:00 Board Meeting Adjourns

Consumer Council Meeting Overview
October 6, 2004

NQF Structure – adding a 5th council for healthcare technology companies. During the Executive Session for this meeting, the Board will discuss by-laws matters related to Board turnover and creation of the Technology Council, which passed the Board by significant margins but for which a few Board members have asked for additional discussion.

Discussion – balance of power
1. Issues for consumer/purchaser representation – may affect original plan for consumer/purchasers to have a 50% or greater representation on Board of Directors
2. technology companies may be special interests rather than "council"-worthy

Action – reflect to Board of Directors consumer concerns with lack of communication with the members

II Officer appointment process and criteria
Process needs to be clearly defined
Term limits – support for organizational health
Succession – Vice-Chair to Chair (should not necessarily mean Vice-Chair automatically becomes Chair)

October 7, 2004

Executive Session Bylaws/Organizational structure
1 John Rother accepted Vice-Chair; BOD ratified
2 Process for by-law change is a BOD decision
3 NQF will commit to increased input around process changes
4 Governance Committee to clarify process for bylaws changes, ratification, and Board member/leadership evaluation
5 Current Board member seats to be extended through clarification process
6 Time frame no later than 12 months

II – Council Structure
1 Suspend implementation vote for an additional council until staff develops decision memo re: merits/issues for changing membership of council

2 Consumer Council input on HCA survey is critical; need clarification on roles/responsibilities of NQF with CMS related to this and other issues

3 Limitation and feasibility of measures discussion needs to be addressed in a more formal discussion by Consumer Council members

Health Professional, Providers and Health Plan Council Meeting Overview
October 6-7, 2004

A luncheon breakout session of the newly renamed Health Professional, Provider and Health Plan (HPPHP) Council was convened. Dr. Sullivan informed the group that over 100 members of the council, whose new name had recently been approved, had registered for the meeting.

Dr. Sullivan said that she is running for a second (and final) term as Chair of the HPPHP Council. There will be two ballots: one for Chair and the other for Vice Chair. Any member in good standing may run for either position. More details about this process will be distributed by NQF through e-mail. For purposes of expediency, Dr. Sullivan asked that the agenda that she had previously distributed by grouped into three areas, with 15 minutes devoted to each subject.

National Voluntary Consensus Standards for Home Health Care

Comments on the National Voluntary Consensus Standards for Home Health Care are due to NQF on October 12. One concern expressed related to the undue burden that would be created with the data collection effort. Another concern related to the need to adequate risk adjust before moving into paying for performance for OBQI. These measures may not necessarily replace OASIS, but might pose an additional burden; those home health agencies not doing Medicare/Medicaid would have a competitive advantage.

The people expressing these concerns were asked to submit them in writing to Dr. Sullivan who could then disseminate them to the "unofficial" e-mail distribution list she maintains. Otherwise, if comments are submitted directly to NQF, they will be posted on the NQF website.
Issue: Most NQF measures to date have been process measures. Comment on the suggestion that outcome measures would unleash more enthusiasm and creativity among health professionals and providers.

Some hospitals are being burdened by ore process measures. With multiple organizations, we might look more toward outcome goals. It is particularly difficult for hospital systems without electronic health records (EHR)

to use process measures when they have to rely solely on reviewing charts for this purpose. Outcomes measures would foster more enthusiasm.

It may be premature to abandon process measures; over time, we'll see that outcomes have improved. Although it may be more of a burden, we should support process measures. Outcomes measures are a good objective; however, the smaller facilities have more difficulty pulling clinically significant outcome data. Consequently, it might be better to develop critical few measures that we could tackle. The results of outcomes measures may not be known right away. For example, one hospital struggles with the ultimate outcome of the smoking cessation measure. Therefore, we should use "smarter" measures and more outcomes will come in along the way.

There is a struggle with the numbers to get clinically significant data. We are probably not ready for outcomes measures, particularly since the physicians were never trained in this process.

The key quality factors should really be our focus. Some key factors are geared toward outcomes. We need to remain focused on the IOM measures (safe, effective, etc.)

We need to get physicians more involved in this process. Incentives are not completely aligned between them and those of the hospitals. Measuring key outcomes is important, but we should be selective (for example, coronary bypass surgery) and other outcomes in similar procedures will also improve.

Issue: Quality of member participation

One new member seemed overwhelmed with the amount of information to process from NQF with virtually no instruction.

A cardiac surgeon discussed the need to get physicians more involved in what NQF is doing. Incentives to physicians are not completely aligned with those to hospitals. Also, measure outcomes are important, but key outcomes should be selective (e.g., coronary bypass surgery) and then the outcomes in other similar procedures will also improve.

Governance Issues
Three straw polls were distributed to each table. For the following two questions, members were asked to approve, oppose, or abstain:

- Expedited Review of AHRQ Quality Indicators: 3 abstain, 32 approve, 30 oppose
- Expedited Review of Palliative Care Framework: 9 abstain, 14 approve, 36 oppose
- For the following question, members were asked to support (or not oppose), oppose (but not a major concern), strongly oppose, or abstain:

Elimination of Directors' Term Limits: 1 abstain, 8 support, 18 oppose, 30 strongly oppose
They were also asked whether the HPPHP Council should institute a self-imposed term limit should the Board pass the resolution. Of those responding, 27 answered "Yes" and 10 answered "No."

- Support (or do not oppose) Board proposal to add a fifth Technology Council: 15 support

- Support (or do not oppose) adding a fifth council if it covers Health Related Goods, Services and Technology: 8 support adding a fifth council to be called a Vendor Council

- Oppose any changes to Council structure: 26 oppose

- Because of its unwieldy size, the HPPHP Council should be divided into three components: Health Professionals, Healthcare Providers, and Health Plans: 28 support splitting the council, 10 oppose splitting the council, and one person commented that it might be appropriate to divide the council into subcommittees

Expedited Review: Under expedited review, there would be no general call for measures, but there would be a full comment period and full voting period.

Term Limits: The Board had previously voted on this, but because of expressed concerns, the issue is being revisited. If term limits are imposed, should they also be imposed for our council?

Modification of the NQF Council structure: One issue is the possible addition of a fifth council. In addition, a suggestion posed by Jed Weissberg, MD, Vice Chair of the Council, had been to divide the HPPHP Council into a more manageable group size (e.g., providers, professionals, and health plans).

One attendee noted that adding a fifth council (or eliminating term limits, for that matter) would require amending the NQF bylaws, which can only be amended by the Board of Directors. It is rather unusual that the

Board, rather than the members, have the authority to amend the by-laws. Rather, having members approve modifications to its bylaws ensures that there will be an open discussion of any changes to the organization. In fact, as an organization, NQF is probably now mature enough to have members chime in on such bylaws issues. The process as proposed by NQF seems to be a rather closed loop—especially have the Board of Directors amend the bylaws to eliminate their own term limits. The concern is that there has been no membership discussion of the important ramifications of adding a fifth council, particularly how it would affect the consensus process. Before such a modification is approved, there should be an open discussion of all the implications.

Expedited Review: One person involved with the palliative care measures suggested not including these measures as part of an expedited review process. AHRQ may also have concern about expedited review of palliative care measures because of the refinement process.

Another member said that what seems to be missing in expedited review is steering committee or technical advisory panel review. Dr. Sullivan clarified that there still would be a committee as part of an expedited review process, but with a different name than a steering committee. Don Casey also explained that three meetings in Washington with a technical advisory panel in the background wouldn't be necessary, but the rest of the process would essentially be the same. One drawback noted by another member was that expedited review would lose the perspective of differing constituencies from various backgrounds that ordinarily would be found in steering committees. Finally, one person commented that technical review needs to be more transparent.

Purchaser Council Meeting Overview
October 6-7, 2004

General
The Purchaser council discussion centered on two main items: 1) applications for membership submitted by various organizations and 2) the forthcoming proposal to be made by Dr. Kizer regarding the establishment of a Technology council.

Applications for Membership
Members of the council briefly discussed the meaning of membership and how a determination is made to accept or reject an organizations membership application. Some members expressed views that payment of dues constitutes membership, while others felt that the organization would have to apply to be a member in the appropriate council before membership would be granted. This discussion led to a more detailed dialogue concerning the establishment of a Technology council.

Technology Council
Members of the council discussed their apprehension regarding establishing a separate council for technology. Most members felt strongly that the current four councils adequately capture all healthcare stakeholders and felt that "technology" companies/organizations could "fit" into one of the existing councils. The main concern held was that there was no clear definition of what was meant by "technology". Members felt that the term was too vague and would enable many companies that were not promoting the "public good" to become members (i.e. those who are strictly for profit entities). Other concerns raised were the fact that the technology council could possibly be able to exert more influence over the consensus-development process as a result of access to significantly more resources than the 4 existing councils.

The council voiced their support to vote against the establishment of a Technology council at the future BoD meeting.

Research and Quality Improvement Council Meeting Overview
October 6, 2004

Council Chair Dr. Bill Golden opened the meeting. He said that the council has received a letter from Dr. Ken Kizer responding to its concerns about the existing ACE heart failure measure and the need for a mechanism to update measures in general. Dr. Kizer's response said there would be a workshop on the heart failure measure in November. The note also included information on a proposal for a standing NQF committee to address changing science and updating measures. Dr. Golden noted that the council should participate and play a large role in this committee's processes.

The council discussed upcoming elections and transitions. Dr. Golden noted that the council had expressed a desire to change its election process to vote for a chair and chair-elect with 2-year terms. However, NQF said that they could not act on the council's election proposal because it would involve a bylaws change that could not be acted on in time for the election. NQF, due to concerns about a substantial turnover of board members, also planned on eliminating term limits of existing board members and the

matter was to be discussed at the executive session of the board meeting. Dr. Golden reported that he had informed NQF staff and the board that the RQI council would oppose elimination of term limits, but could support modification of existing bylaws to deal with immediate turnover concerns. Despite not being bound to a term limit, Dr. Golden said he would not seek reelection to the council chair. The council agreed to direct staff to run the upcoming 2004 council election for a chair and vice chair.

Dr. Golden sought input from the council about satisfaction with council services. He noted that about one-third of council members are voting on measures and generally about 20 people join council conference calls. The council agreed that the conference calls were useful. A council member noted that many votes and calls are on issues that impact only a small portion of members, and those not involved tend not to participate. Also, a member noted that more notice should be given prior to conference calls (2 weeks). Another member noted concern about whether or not NQF will supply a council secretary following the outcome of the election. The council noted the tremendous contributions made to NQF by Dr. Golden.

On communication, Dr. Golden inquired if council members shared his concerns about NQF communications to board members and NQF members. One member asked for more information from NQF staff on where existing projects stand. Another member noted that having many projects in expedited review likely would compound the communication problems. It was suggested that one section of regular NQF e mails to members could include a one page project status summary to allow members to track ongoing initiatives. Council members added that the current email communications are unorganized and don't provide satisfactory information on projects. Another member noted that it would helpful if someone could screen through important comment letters on projects and direct them to members' attention, as opposed to having members scan through hundreds of comment letters. Members agreed that they are willing to serve as ad hoc reviewers of comments to identify higher priority items for council wide attention.

Dr. Golden posed some additional questions to the council: In terms of measures, are we getting volume at the expense of quality? A general discussion about measures and their utility followed. It was felt that the RQI council had specific expertise and importance in assisting the NQF sort through the nuances of measures for improvement, accountability, and community understanding. A member voiced concern about the utility of the measures for consumers making health care decisions, and whether publicly reporting measures is making a difference.

October 7, 2004

Dr. Golden provided an update on upcoming issues for the rest of the Annual Meeting as well as information about upcoming meetings. The council discussed the document produced by the Consumer-Purchaser Disclosure Project for the intercouncil meeting.

Dr. Golden announced that during the board meeting, the board endorsed the proposal to create a committee to look at measure maintenance and revision. The board also discussed a proposal to add a 5th member council for technology. The provider council was uncomfortable with the proposal. It was sent back to the governance committee for the creation of a full proposal and an assessment of its impact on bylaws. The board decided to rescind term limits for at least year until the governance committee can devise a full proposal. A council member noted that a 5th council is an important consideration as it could dilute the council's power. Another member noted that, as a software vendor, they'd prefer to continue participating in the RQI council. The council also discussed the pros and cons of term limits, and ways to maintain institutional memory (such as staggered terms). Council members urged Dr. Golden to again make these points during the public meeting of the board.

Council members again called for NQF to examine whether it is adhering to its strategic plan in the endorsement of measures, and again should examine the business model for the organization.