The National Quality Forum
Annual Meeting 2005

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ABSTRACT

PURPOSE: The National Quality Forum's (NQF's) 6th Annual Meeting, "The Accountability and Transparency Puzzle: Implementing NQF-Endorsed ™ Consensus Standards," provided a forum for Members and other stakeholders to discuss and share information on the implementation of national voluntary consensus standards endorsed by NQF. As the number of endorsed standards increases, the importance and challenge of broad implementation becomes even more critical. The Annual Meeting provided a venue for multiple organizations to share best practices and discuss the barriers and solutions to implementing the voluntary consensus standards.

SCOPE: More than 325 individuals from 220 organizations attended the meeting. The sessions dealt with issues ranging from pay for performance to implementation of measures at both the national and local levels. The sessions involved stakeholders from all areas of healthcare sharing their perspectives on system-level issues as well as specific priority areas.

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

RESULTS: Participant evaluation and feedback were positive. We continue to work to incorporate suggestions about providing more time for inter-Council discussions. Attendees took away from the meeting more than handout materials—they took away practical and constructive ideas and suggestions for implementing endorsed voluntary consensus standards.

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

PURPOSE

The National Quality Forum's (NQF's) 6th Annual Meeting, "The Accountability and Transparency Puzzle: Implementing NQF-Endorsed ™ Consensus Standards," provided a setting in which to foster dialogue and information sharing among all healthcare quality stakeholders involved in the implementation of NQF-endorsed national voluntary consensus standards. This included discussion and information sharing related to approaches to implementation and to the challenges and barriers that need to be overcome.

By bringing together speakers throughout the healthcare quality field, the 6th Annual Meeting:

- promoted the dissemination of best practices and experiences that informed the end-users about what implementation really entails. The "real-life" stories of the actual implementation of NQF-endorsed consensus standards – including lessons learned – allowed the end users to learn from each other in a cooperative and supportive environment;
- allowed attendees to hear from various groups on how they were using NQF-endorsed standards when evaluating or comparing healthcare performance. The issue of pay for performance was a major focus of the conference; and
- highlighted tools to assist stakeholders in implementing endorsed measures. Interactive sessions among the Members allowed further collaboration to ensure the tools were made available.

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 6th Annual Meeting was held October 6-7, 2005, at the Grand Hyatt in Washington, DC. "The Accountability and Transparency Puzzle: Implementing NQF-Endorsed™ Consensus Standards" focused on the implementation of national voluntary consensus standards for healthcare quality.

NQF's member organizations represent the total spectrum of healthcare stakeholders and are categorized within four NQF Member Councils (Consumer Council; Purchaser Council; Health Professional, Provider, and Health Plan Council; and Research and Quality Improvement Council). 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 325 individuals from 220 organizations attended the meeting, which included participants from both the public and private sectors. (See appendix C 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 that included open discussions about NQF policies and implementation and use of NQF consensus measure sets;
- Meeting of the NQF Board of Directors.

RESULTS

October 6, 2005: Opening Plenary Session

Health and Human Services (HHS) Secretary Michael O. Leavitt spoke about the newly created American Health Information Community (AHIC) and the Bush Administration's initiative for most Americans to have an electronic health record within 10 years.

AHIC will advise HHS on how to accelerate the nationwide adoption of interoperable electronic records while striking the right balance between a focus on the public and private sectors. AHIC will have five specific tasks:

1. Make recommendations on how to protect privacy and security.

2. Identify and make recommendations for prioritizing health information technology achievements that will provide immediate benefits to consumers of healthcare (e.g., drug safety, laboratory results, bioterrorism surveillance).

3. Make recommendations regarding the creation of a private sector, consensus-based, standard-setting, and harmonization process and a separate product certification process.

4. Make recommendations for the development of a nationwide architecture that uses the internet to share health information in a secure and timely manner.

5. Make recommendations on how AHIC can be succeeded by a private sector health information community initiative within 5 years. The sunset of AHIC, after no more than 5 years, will be written into the charter.

The national strategy for achieving the interoperability of electronic health information involves having federal agencies—which pay for more than one third of all U.S. healthcare costs—work with private sector healthcare providers and employers in developing and adopting an architecture, standards, and certification process.

Secretary Leavitt noted that HHS will do its part by adopting standards and data-sharing processes for internet-based applications that will help federal programs, such as Medicaid and Medicare, support the use of digital and interoperable health records that are privacy protected and secure.

October 6, 2005—Panel I: Preparing for Pay-for-Performance
Participants: Stephen Grossbart, Daniel Varga, Janet Davis
Moderator: Katherine Browne

Dr. Grossbart spoke about the experience of Catholic Healthcare Partners (CHP) in implementing a variety of reporting systems to support many of NQF's endorsed voluntary consensus standards.

CHP is organized into nine regional service areas in five states and includes 29 hospitals, 14 long-term care facilities, housing sites for the elderly, 10 home health agencies, hospice programs, outreach services, medical groups, wellness centers, and other organizations that operate diversified healthcare activities. The system is the largest healthcare provider in Ohio. CHP also has hospitals located in Kentucky, Pennsylvania, and Tennessee.

Since 2002, CHP has adopted and implemented reports and initiatives around the following NQF voluntary consensus measure sets: hospital care (initial performance measure set), serious reportable events, nursing-sensitive measures, nursing home care, and home healthcare. Since implementing the hospital care measure set in 2003, CHP has improved its overall performance in three priority areas by an average of 20 percent.

Currently, CHP is implementing the nursing sensitive measures set. The organization has supported the development of these measures through participation on the steering committee. Also, CHP was recently selected to participate in the pilot testing of The Joint Commission's nursing-sensitive care measures to develop a technical implementation guide for this measure set.

Dr. Daniel Varga spoke about Norton Healthcare's experience in publicly displaying hospital-by-hospital performance on more than 200 indicators and safe practices. The display includes all of the NQF consensus standards for hospital care, cardiac surgery, nursing-sensitive care, and safe practices. Some of the categories in the report were:

Infection control	Cardiovascular procedures
Surgery	Ambulatory care
Pneumonia	Nursing care
Heart failure	Patient safety
Heart attack	Childbirth

Norton's purpose in publishing its quality performance data was two-fold. First, it believes that the public should be aware of its financial and clinical performance. Second, Norton believes that, although public reporting is still limited, it has helped the organization document care more carefully, obtain more valid data, and provide better patient care than it would have without public reporting.

Visitors to Norton's website can chose whether to read either a technical or a lay description of the measures and learn whether it is desirable for the indicator to be high or low and how the indicator compares to those throughout the rest of the country. For low-scoring indicators, an explanation is provided about a hospital's improvement efforts.

The website has received extremely positive reviews from the public and the media. Although the website has been widely used, there have been no major shifts in patient volume.

Janet Davis spoke about Tampa General Hospital's experience in implementing NQF's nursing-sensitive care measures. Tampa General was already an active contributor to the American Nurses Association (ANA's) National Database of Quality Indicators. However, during its preparations for receiving Magnet Status, the hospital challenged itself to improve its quality improvement program. Tampa General was already an NQF Member, so the

organization agreed to adopt the nursing-sensitive indicators. Implementation required more time, education, and communication than was anticipated. The following implementation strategies were identified:

- develop the communication loop;
- reach consensus on indicator measures;
- determine collection strategies, which included involvement with all staff Registered Nurses (RNs);
- develop data collection tools and spreadsheets, which required nurse manager, clinician, and RN staff education;
- collaborate with other departments for data collection;
- develop a system to share data that is understood by the staff RNs.

Hospital staff members now regularly discuss evidence-based practices as part of all performance improvement and research opportunities. Implementing these measures helped the organization improve its performance improvement program, achieve ANA's Magnet Status, and earn 11 Joint Commission Disease-Specific Certifications.

October 6, 2005—Panel II: Measuring Efficiency
Participants: Barry Straube, Margaret O' Kane, Mark Rattray, Kaveh Safavi
Moderator: Benjamin Eng

Dr. Barry Straube, Acting Director of the Office of Clinical Standards and Quality and Acting Chief Medical Officer at the Centers for Medicare and Medicaid Services (CMS), spoke about the Quality Roadmap, an effort that is designed to help bring about a healthcare system that is safe, effective, efficient, patient-centered, timely, and equitable.

CMS has identified five strategies for reaching the goals outlined in the Quality Roadmap.

1) Work through partnerships within CMS and HHS and with other government agencies and private sector partners;

2) Publish quality measurements and information;

3) Use purchasing power to demonstrate commitment to improving quality and reducing costs;

4) Assist providers in taking advantage of CMS quality initiatives;

5) Bring effective innovations to patients rapidly and be an active partner in using information about the effectiveness of emerging healthcare technologies.

Dr. Straube also noted that CMS has undertaken efforts that include pay-for-performance programs for physicians, hospitals, skilled nursing facilities, and home health agencies.

Margaret O'Kane, President of the National Committee for Quality Assurance, spoke about efficiency in a broad, system-wide context. She addressed care coordination, individual physician metrics, payment reform, and patient behavior.

Care Coordination: The sickest patients often see multiple physicians. The healthcare system must recognize this and reward clinically accountable entities, such as coordinated group practices and hospital-centered networks, when they provide this opportunity.

Individual Physician Metrics: Physicians play an important role in improving healthcare efficiency. However, strategies geared solely to the level of the individual physician can cause distortions of practice that can lead to inefficiency.

Payment Reform: Non-payment for medical errors and the elimination of certain incentives that prompt physicians and hospitals to overuse drugs and devices are critically important. The healthcare system needs to establish incentives for efficiency and quality for its providers and consumers.

Bernard Kershner, Chairman of the Accreditation Association for Ambulatory Healthcare (AAAHC) Institute for Quality Improvement, spoke about his experience establishing one of the first pediatric hospital-based ambulatory care facilities in the country.

In the 1970s, when Mr. Kershner was president of Albert Einstein College Hospital, ambulatory care was a fledgling idea. There were no licensing regulations, no accreditation bodies, and no oversight. However, the center Mr. Kershner helped establish became extremely successful. To demonstrate its dedication to providing the highest quality of care, the facility established benchmarking practices and conducted patient and physician satisfaction studies. Some of these studies examined anesthesia complications, infection rates, and turnaround time between cases, and others looked at the economics of ambulatory care.

Once the facility was fully functional, it handled up to 4,300 cases each year on a site with two operating rooms and a total space of under 6,000 square feet. Mr. Kershner's experience shows that measurable quality and efficiency need not be mutually exclusive.

Dr. Mark Rattray spoke about efficiency measurement and its shortcomings. Efficiency usually is measured with software algorithms that process claims into discrete "episodes of care." The software's underlying principle is to compare aggregate costs to treat a specific condition over time with the cost averages of market specialty peers. The market can be defined as encompassing a city, a state, a region, or nation. The programs provide detailed reports showing areas of significant variance.

Software designed to measure efficiency has several shortcomings. Each program has its individual settings, which makes standardizing the output reports difficult. The report's definition of the sample size also can be problematic. A physician may not see enough patients with a particular condition for his or her results to be considered statistically valid or reliable. Defining an accurate peer group can also be a problem, because, for example, many physician directory listings may not accurately represent how physicians are practicing. Also, it can be difficult to attribute data to a specific physician in cases where more than one physician ordered or provided services.

Dr. Kaveh Safavi from Solucient, a hospital consulting company, spoke about efficiency from the hospital perspective. Hospital payments are based on averages. Hospitals usually determine efficiency by calculating a ratio based on a relatively large market basket of services and a relatively large market basket of payments. However, such an average contains a vast amount of variation. Although a conversation about averages can be motivating, it is not necessarily informative in terms of facilitating institutional change. Efficiency is usually measured by comparing individual results to a normal distribution. By contrast, Solucient gives its clients a large choice of observed values and allows them to decide which they think is most similar to them; clients are then sampled against their selections.

Dr. Safavi believes that most of his client's improvements came from the conversations about the efficiency information rather than the efficiency information itself. Therefore, in order for the information to be of any value, it is critical that it be credible, understandable, and actionable to the people who must actually change their practices.

October 6, 2005—Panel III: Focus on Priority Areas
Participants: Michael O' Toole, David Wong, Yosef Dlugacz
Moderator: Rita Munley Gallagher

Dr. Michael O'Toole, a cardiologist and Chief Information Officer for Midwest Heart Specialists (MHS), spoke about implementing measures in a private practice. MHS is an unusual practice in that it has been using electronic health records since 1997. Dr. O'Toole explained that electronic record keeping in cardiology applies to the outpatient practice as well as the inpatient practice. Patients with pacemakers and defibrillators need to be monitored outside of the practice, and all of the data need to be instantaneously accessible when the patient arrives at the office.

MHS implemented the American Medical Association (AMA) Physician Consortium for Performance Improvement measures. The AMA Consortium Performance Measures are the only physician-led consensus performance measures and the only set that can bring together the American Heart Association, the American College of Cardiology, and the AMA. The standards are also endorsed by CMS, the Agency for Healthcare Research and Quality (AHRQ), and NQF. Dr. O'Toole showed how his practice fared using performance measures for coronary artery disease patients, heart failure patients, and diabetes patients. Smoking cessation counseling, height documentation, and diabetes screening rates all improved. Dr. O'Toole also showed the team report cards that are given to physicians. Although teams do not receive financial incentives, MHS generally found that teams improve quality when they receive the appropriate tools.

Dr. David Wong spoke on behalf of the American Academy of Orthopedic Surgeons (AAOS) about the adoption of the NQF Patient Safety Event Taxonomy as the first step in comparing safety practices in orthopedics with those in other specialties. Otolaryngology was the first to have a specialty-wide patient safety survey. In 2004, 2,500 surveys were mailed to specialists in the field. The surveys asked for a comprehensive list of all errors in the past 6 months, including a description of the error, the consequences, and the corrective action taken. Nearly 500 responses were received that included 216 errors. The authors developed a classification system based on the responses in which errors are categorized into one of 16 classifications. This system differs from the hierarchical NQF Patient Safety Event Taxonomy that is organized according to primary, secondary, tertiary, and quaternary classifications so that it contains groups and subgroups.

AAOS sent surveys to orthopedic surgeons in August and September 2005 and chose a similar format for its surveys of ear, nose, and throat (ENT) specialists. The organization received nearly 1,000 responses and identified about 500 errors. An analysis of the responses was conducted using both the ENT classification and the NQF taxonomy. It showed that there are types of error that do not fit into either classification system (e.g., patient falls, retention of objects in surgical site, and incorrect identification). Agreement is needed on how to classify these and other errors before any meaningful comparison work can be done.

Dr. Yosef Dlugacz spoke about the challenges that North Shore-Long Island Jewish Health System (NS-LIJHS) experienced in implementing measures. In CMS's pay-for-performance program, compliance at NS-LIJHS was low for one of the most simple indicators—smoking cessation counseling for high-risk patients (e.g., patients with acute myocardial infarction, heart failure, pneumonia). Dr. Dlugacz could not explain the low compliance on such a simple indicator, and he noted that employees were failing at other simple measures as well.

To improve compliance rates, NS-LIJHS revised one of its existing tools, CareMap, which helps direct care toward evidence-based best practices by providing a standard of care for varied patient populations with discipline-specific goals, focusing on patient and cost outcomes. CareMap increases collaboration and efficiency by prospectively planning for care, and it strengthens accountability by linking assessment and intervention strategies with patient outcomes. However, CareMap does not include relatively simple processes, such as smoking cessation counseling. Medical staff, cardiologists, nurse practitioners, and physician assistants had to join together to write an algorithm to document the process of counseling. Previously, doctors left smoking cessation counseling to nurses. Since CareMap's revision, rates of smoking cessation counseling for patients with acute myocardial infarction, heart failure, and pneumonia have improved.

October 6, 2005—Panel IV: States, Systems, and Collaboratives Get in the Act
Participants: Dennis Shubert, Mike Kern, Caron Lee
Moderator: Steve Wetzell

Dr. Dennis Shubert, Executive Director of the Maine Quality Forum (MQF), spoke about the organization's role in state health reform and the success it has achieved. MQF is a state agency that collects research, promotes best practices, collects and publishes comparative quality data, promotes electronic technology, and promotes healthy lifestyles. It reports to Maine's consumers and government. The organization has an advisory panel that consists of stakeholders from provider, payer, consumer, and insurer communities. The Governor and the legislature established MQF as part of the Dirago Health Reform legislation, with the hope that the quality and access initiatives on which MQF is working will generate savings that can be used to help the uninsured and facilitate improvements in other health-related issues.

Dr. Shubert explained that the major advantage of being a state agency working in healthcare safety and quality is the ability to shape the rule-making process. In Maine, rules relating to quality in healthcare require a public hearing and legislative approval. This opens up the process to all stakeholders. MQF was successful in getting stakeholder consensus and legislative approval of the CMS Quality Indicators, which are now the responsibility of all hospitals in Maine, including critical access hospitals and independent ambulatory surgery centers. MQF also won legislative approval of the NQF nursing-sensitive measures, although stakeholder consensus was not achieved.

Dr. Mike Kern, Quality Manager at John Muir Health System, spoke about health information technology and the health system's experience in reporting quality measures. He began by describing some of the information technology patient safety efforts that are under way at Mt. Diablo hospital. System-wide decision support will allow the institution to manage inpatient and outpatient data across the continuum and will be available in 2006. Clinical alerts will be availale in 2009 to continuously monitor data and alert clinicians when a negative trend occurs. Pharmacy decision will be availablein 2006 to support will improve monitoring of patients to allow early discovery of negative physiologic trends as will a pharmacy robot, which will enhance dispensing accuracy.

John Muir Health system began public reporting on 10 inpatient measures this year. Teams of hospitalists admit patients in all of the system's hospitals.

Consequently, their scores, in large part, constitute the scores of the entire system. Adopting the NQF guidelines will help drive the system in the right direction. To encourage quality improvement, Dr. Kern provides teams reports that compare one hospitalist group to another and gives teams regular updates on their performance according to NQF guidelines.

Caron Lee spoke on behalf of the Institute for Clinical Systems Improvement (ICSI). The topic of Ms. Lee's discussion was the application of NQF standards for diabetes care and patient safety to the ICSI collaborative. ICSI was established in 1993 to accelerate improvement among its member medical groups and hospitals. Its unique program model includes the Core Commitment Cycle wherein members choose four topics each year on which to focus. Starting in 2002, ICSI started selecting ICSI-wide initiatives that it strongly encouraged its members to adopt as part of their Core Commitment Cycle. Action groups help members in choosing the ICSI-wide initiatives.

The diabetes action group, founded in 1997, was the first action group established by ICSI. It draws on several models, including the chronic care model and the ICSI guidelines on adult diabetes care, and it engages patienthood. The tools and strategies on which the action group focuses are registry development, visit planning, patient self-management, group visits, outreach, and provider and staff education. The NQF standards drawn upon by the diabetes action group are screening frequency for glycemic control and lipid profiles, outcome measures for glycemic control (with HbA1c <7 percent) and lipid levels (LDL <100mg/dL), and blood pressure value (<130/80 mmHg). Data from the diabetes action group revealed statistically significant improvement in glycemic control, LDL level, and hypertension control. This success has prompted all ICSI action groups to use NQF measures to assess their performance.

October 6, 2005—Panel V: Pay-for-Performance Programs
Participants: Karen Davis, Meredith Rosenthal, Andrew Webber, Arthur Levin
Moderator: Jeffrey Rich

Dr. Karen Davis, President of the Commonwealth Fund, spoke about the pros and cons of different payment systems, including pay for performance. Healthcare payment systems are either fee-for-service or capitation systems. Fee-for-service systems are criticized because they do not reward quality, episode efficiency, or prevention. However, they do reward efficiency when providing an individual service.

Capitated systems reward efficiency in individual service, episode efficiency, and lowest-cost care over time. However, they do not reward quality, patient outcomes, or patient-centered care.

Pay for performance uses positive financial incentives to reward structures, processes, or outcomes of care. Providers can be judged by technical quality indicators, patient experiences, efficiency, and the extent to which they have instituted information technology systems. However, a number of issues must be resolved before pay for performance can be instituted. These include fine-tuning the performance measures, choosing between a percent add-on to fee-for-service or a lump sum per provider, financing the rewards, and dealing with unintended consequences. The largest pay-for-performance program in the United States is the Medicare group practice demonstration in which providers have quality and cost targets. To obtain a reward in this program, a group practice must provide 60 percent of its care to Medicare beneficiaries and meet certain quality targets. If, over 3 years, Medicare spending grows by two percentage points less than the Medicare spending of a comparison group of local Medicare beneficiaries, the group practice gets to keep 80 percent of the savings.

Dr. Meredith Rosenthal from Harvard University spoke about pay for performance, the challenges it creates, and its shortcomings. She compared the existing demonstration projects to Phase I drug trials because of their scope. Internal, uncontrolled studies by Premier and IHA suggest that pay-for-for-performance programs resulted in quality improvement. Dr. Rosenthal stated that early evidence from formal evaluation may provide a more nuanced picture, with small effects, in some instances (that are nonetheless consistent with pay-for-performance theory), and improved documentation appearing to play a larger role than previously thought.

Several issues must be addressed in order for pay for performance to take root. These include making rewards more salient to increase the impact on quality improvement. A provider must invest in time, effort, and foregone revenues to improve quality, and the incentive offered by a pay-for-performance system must obviously be greater than the initial cost, if the system is to succeed. Current pay-for-performance models offer incentives that are too small to motivate all providers in the network. Another challenge relates to quality and cost-efficiency. The initial focus of pay for performance was on measures of underuse. Few such quality targets, however, will reduce costs. In addition, research does not show an association between quality and cost. To address this, efficiency measures are increasingly a target of pay for performance. Pay for performance requires either the coordinated action of many payers or decisive action by a major player, such as CMS.

The greatest challenge will be minimizing the unintended consequences of an incentive system.

Andrew Webber, President and Chief Executive Officer of the National Business Coalition on Health (NBCH), spoke about pay for performance from a purchaser perspective. NBCH seeks to use the influence of purchasers to advance payment reform in the health system. Advancing payment reform requires cooperation of healthcare plans. It is essential that healthcare plans in a given market agree to a standardized set of measures before pay for performance can firmly take hold. Coordination on public reporting strategies also may be useful. Mr. Webber also stated his belief that an incentive system should reward not only the top-tier providers but also all providers who demonstrate improvement. He concluded by stating that the financial thresholds to motivate provider and consumer behavior have not been found and crossed. The incentives are not sufficient in current models to energize and engage the provider community. Financial incentives, such as benefit design, adjusting co-payment and co-insurance, and lowering co-payments, can get consumers more engaged in making selections based on performance information.

Arthur Levin, Director of the Center for Medical Consumers, spoke about pay for performance from the consumer perspective. He speculated that, if one were to ask the average consumer what he or she thinks about pay for performance, the consumer would be surprised that the current reimbursement level is not sufficient to buy good quality healthcare. In addition, the consumer would probably wonder whether a system that large and expensive should be held to a higher level of consumer accountability. Incentives in pay-for-performance programs are based on self-reported information. Mr. Levin suggested that the pay-for-performance model should incorporate meaningful, independent oversight in order to eliminate a likely source of public distrust.

John M. Eisenberg Patient Safety and Quality Award Presentation

The National Quality Forum and The Joint Commission awarded the 2005 John M. Eisenberg Patient Safety and Quality Awards. The honorees, by award category, were as follows:

Individual Achievement: Audrey Nelson, PhD, RN. Dr. Nelson has led an array of research projects at the Department of Veterans Affairs (VA) Patient Safety Center of Inquiry in Tampa, Florida, to improve the quality of care delivered to people with disabilities. A nationally recognized leader in clinical practice and research, she has magnified the scope of practice for patient safety and is a tireless advocate for those with disabilities. Her research in redesigning at-risk tasks in nursing, creating algorithms for safe patient handling and movement, preventing wheelchair-related falls, and other interventions that are being used nationally. Dr. Nelson has received numerous awards and honors, including the National Veterans Affairs Excellence in Nursing Award, six national VA Rehabilitation Nursing Awards, two research utilization awards, and the VA Alumni Association Honorary Leadership Award. She serves on numerous advisory boards, review panels, and collaboratives. Dr. Nelson received a BSN from the University of South Florida in 1977, a master's degree from Emory University in 1980, and a doctorate in nursing from the University of Florida in 1990.

Innovation in Patient Safety and Quality–National/Regional: Maryland Patient Safety Center. The Maryland Patient Safety Center implemented a unique and comprehensive statewide approach to patient safety improvement by bringing together a public-private partnership of healthcare providers and policymakers to study and learn from errors. Established in 2004 by the Maryland Healthcare Commission, the center seeks to make Maryland hospitals and nursing homes the safest in the nation. The center’s director is William Minogue, MD.

Innovation in Patient Safety and Quality–Local/Organizational: Meridian Health. Meridian Health of Neptune, New Jersey, realized significant improvements in the quality of care delivered to residents of Monmouth and Ocean counties in New Jersey just months after embedding evidence-based best practice guidelines into its computer-based physician order entry system. Physicians have embraced the use of the interactive practice guidelines for online ordering, resulting in the implementation of a dozen best practices throughout the system.

Innovation in Patient Safety and Quality–Local/Organizational: Sentara Healthcare. Sentara Healthcare, a nonprofit healthcare provider in southeastern

Virginia and northeastern North Carolina, established and continues to promote a system-wide culture of safety through a comprehensive error-prevention initiative. Key strategies include setting error prevention expectations for all staff, implementing a "Common Cause Analysis Program," and redesigning key work processes to foster safety.

October 7, 2005: Member Council Meetings

Each member organization of NQF belongs to one of four NQF Member Councils: Consumer; Purchaser; Health Professional, Provider, and Health Plan; and Research and Quality Improvement. Sessions were primarily business and content meetings that focused on ongoing discussions of NQF projects, NQF and Council operations, and the implementation of NQF measure sets.

October 7, 2005: Board of Directors Meeting

Dr. Kizer reported that, because copies of his report had been made available (see Appendix A), he would forego providing a detailed report. He noted, however, that, with the membership applications approved during this meeting, membership now stands at 285. Dr. Kizer also provided an update on the two Ad-hoc Committees. He noted that the Criteria Committee had been charged with recommending whether NQF should be endorsing only accountability measures or whether it also should be endorsing quality improvement-only (QI-only) or community-level surveillance measures. Dr. Kizer stated that the committee had preliminary recommendations and should finalize its recommendations in the near future, after which Members will be given an opportunity to comment before the board adopts a policy in this regard. Dr. Kizer noted that NQF staff members have developed, and the Grading Committee is reviewing, an instrument for grading the evidence underlying measure evaluations. He reported that, although the committee has met by conference call, it had no preliminary conclusions or recommendations, and it would likely need to meet in person.

Member Council Reports

Dr. Sullivan reported on the meeting of the Health Professional, Provider, and Health Plan (HPPHP) Council. She also noted that there had been a joint breakfast meeting of a small group of HPPHP Members with the Consumer Council. Dr. Sullivan stated that, although she had not been able to attend that session, she understood that productive dialogue and discussion had occurred. She also noted that the HPPHP Council had established a subcommittee to look at ways to support communication and participation within the Council and that the Committee looked into so-called social software. Dr. Sullivan requested that NQF pursue this strategy, which would be web-based as a way of supporting discussion and communication within and among Councils, Member comments on projects, and voting.

Dr. Nishimi responded that NQF had looked into the software options, but that implementing them is a financial issue. Dr. Sullivan said that she believed that, given the amount of money spent on FedEx, such funds could be redirected in this regard.

Dr. Sullivan reported that the HPPHP Council also had discussed the Ambulatory Quality Alliance (AQA). She stated that the HPPHP Council spent time discussing its priorities in order to respond to Dr. Kizer's request that Members make recommendations on what they see as the top priorities over the next 2 to 3 years. Dr. Sullivan said the HPPHP Council's general thrust was that the Board should recommit to measures across all six NQF-endorsed domains of quality of care (safe, effective, beneficial, patient-centered, efficient, and equitable). She stated that measures of equity were mentioned as being especially needed, as are measures of safety and care coordination. Based on a straw poll, however, the following types of measures were identified as the highest priorities: measures for specialty care, measures for pay for performance, efficiency measures, and obstetrics quality of care measures.

Finally, Dr. Sullivan said that the HPPHP Council engaged in a lively discussion on whether NQF should endorse only measures for accountability or should endorse both accountability and QI-only measures. She stated that the discussion had been somewhat conflicted because concerns existed that the endorsement of QI-only measures might result in their being "misused"—in most HPPHP Council members' views—for accountability. On the other hand, her Council believed that it was urgent that standardized QI-only measures be available. Dr. Sullivan reported that, ultimately, the HPPHP Council's straw poll voted 50 to 5 in favor of NQF endorsing QI-only measures.

Mr. Lindberg reported that the Consumer Council appreciated the opportunity to meet with representatives of the HPPHP Council. He said that further dialogue on the details about implementation of consensus standards was of interest, in particular the specifics about the issue of burden. Mr. Lindberg stated that, like the HPPHP Council, the Consumer Council identified three priorities for NQF, as follows: first, continue with the core mission to endorse consensus standards for public accountability; second, ensure that NQF maintains these measures and also focuses on integrating new measures into the sets, given that parties agree that these were intended to be initial sets and many important care aspects are not addressed; and third, increase attention on monitoring how NQF measures are being used. With respect to specific measures, Mr. Lindberg reported that the Council places its highest priority on implementing measures that already have been endorsed, and it strongly favors pursuing measures related to pediatrics and infection control.

Mr. Lindberg noted that the Council also would like to push forward as priorities measures related to safe practices, coordination of care, and obstetrical care. Ms. Ness added that the Council discussed ongoing efforts to recruit more consumer organizations to participate in NQF.

Mr. Queram reported that the Purchaser Council spent much of its time talking about the issue of purchaser engagement. He stated that what came out of the discussion was a sense that the NQF mission and business model may not intuitively align with the interest of purchasers. He further noted today's reality is that an increasing number of employers are looking for ways to get out of providing healthcare, or at least diminish their level of involvement, because healthcare is not their core business mission. He further stated that some of the very things that make NQF's consensus focus strong from a process standpoint are turnoffs to employers. Mr. Queram also noted that the dues structure for many in the private sector is prohibitive because the level of financial commitment is above the signature authority of the people often assigned to attend or participate in NQF activities. Mr. Queram stated that many employers do not see NQF as important relative to other initiatives for which the value proposition is clearer. Mr. Queram said the Purchaser Council identified four NQF areas that need to be addressed: present a clear value proposition to employers; identify reasonable payback or return on investment from participating in NQF; bring a sense of urgency and accomplishment to such participation; and make changes to the cost of participation. Mr. Bradley said Mr. Queram's summary was well done; however, his position was that purchasers' interests are aligned with respect to the importance of the work that NQF does. Mr. Bradley said that he believes the problem is that different purchaser cultures do not value this alignment.

Dr. Brock reported that the Research and Quality Improvement Council also discussed the issue of NQF endorsing QI-only measures. She stated that the members clearly accept that NQF's mission is to endorse measures for accountability and that there are other entities to aggregate QI-only, in particular AHRQ's National Quality Measures Clearinghouse. At the same time, Dr. Brock noted that some Council members clearly believe that standardization and NQF endorsement of QI-only measures is important—especially from a developmental perspective. In this regard, Dr. Brock also reported that the work of Steering Committees and Technical Advisory Panels might be viewed as more meaningful, even if measures fall short of endorsement.

Dr. Brock said that the RQI Council also discussed what could be done to integrate, and hence streamline, the various processes for measure developers. For example, she suggested that, if a measure is submitted to NQF and it is not endorsed, it should be easy for the developer to transition that measure into the National Quality Measures Clearinghouse.

Additionally, she reported that Council members believed that it would be helpful to provide a checklist to help identify the reason(s) why a measure did not reach a threshold for accountability.

In terms of priorities, Dr. Brock noted that the Research and Quality Improvement Council believes that the gap of greatest concern are efficiency measures which should not simply be resource allocation-type measures, but rather the benefits divided by resource use. She said that AHRQ has an evidence review contract with RAND to do a literature review of efficiency measures, which is due in approximately one year. She also noted that the Council felt that the Institute of Medicine (IOM) has already established priorities for healthcare quality; thus, members did not further discuss specifics. Other areas that were mentioned as high priorities were safe practices; a further definition of criteria for pay-for-performance programs; patients who have multiple medical problems in chronic care; measures for specialty care; medication safety; healthcare-associated infections; appropriateness of care; stroke; and care in intensive care units.

Dr. Brock reported that the Council also discussed the Call for Measures process; several measure developers were concerned about the liability language in the standard NQF intellectual property agreement. She noted that the concern involves the fact that a measure developer must accept liability for any bad outcome associated with the measure's use.

Evaluation of the Conference

NQF employed a number of strategies to evaluate and document the participation, experience, and outcomes of the 2005 Annual Meeting conference. In addition to last year's methods, staff members decided to add an additional element in order to get more direct feedback from participants about each conference session.

◊ Attendees were able to provide comments about each individual session. The conference session evaluation form asked participants to rate the overall effectiveness of each session and to identify the types of activities used by the presenters, what aspects of the conference were most helpful, what was missing, and what changes they would suggest for next year.

◊ NQF provided staff conference "documenters" who attended each session and took notes about the content of the sessions.

The program had the best attendance of meetings and conferences that NQF has convened, and participants were generally satisfied with the plenary and breakout sessions because they provided high-level policy briefings on a number of timely and important policy issues.

Specific Comments

- ◊ I would like to be able to review related selected readings on the meeting.
- ◊ Consider mixing plenary and Council; appreciate all the hard work in putting the meeting together.
- ◊ Please advise presenters to eliminate from their PowerPoint presentations those slides that they identified as "bad slides" or "difficult slides to view."
- ◊ A full day of plenary sessions does not allow much "mixing" for attendees; hold one set of break out sessions.
- ◊ Request representation of an "orphan" medical specialty that is hospital based.
- ◊ Please have slides for all presentations prior to meeting or at least in the packets.
- ◊ Some of the presenters on the panels were great, while others had good material but not enough time.
- ◊ Provide handout for all PowerPoint presentations; post them on the website or have updated handouts if speakers changes slides; Council did not roll out well -get better organized.
- ◊ Appreciated learning about efficiency measures and seeing implementation examples.
- ◊ Please plan for more hospital presentations; would have liked more from NQF, its view as to future direction for metrics.
- ◊ Meeting was well worth attending.
- ◊ All speakers should be required to have audio presentations and copies of presentations distributed to the attendees. Presentations should be placed on a CD for the attendees.
- ◊ Overall, was very well put together; I liked the short speaker time. No time to get bored; great place to hold a conference. Very nice hotel; good food; very helpful staff.
- ◊ If there are NO handouts, please tell us so we don't spend time looking for them instead of actually listening/enjoying the presentation!
- ◊ I always enjoy the NQF meetings - great speakers and networking opportunities. The staff does a fantastic job with the meeting logistics, and I appreciate their helpfulness and hard work in organizing and planning the meeting.

Appendix A

PRESIDENT'S REPORT
for the
NQF Board of Directors Meeting
October 7, 2005

A. Office Management. No significant changes.

B. Staff. There has been one staff departure and some four new arrivals since my last report.

C. Membership. If the applications that are pending Board action are approved, NQF organizational membership will stand at 285.

All Member Councils continue to meet regularly by conference call.

The Spring Membership meeting was held on May 10, 2005, at the Downtown St. Louis Marriott; feedback from the meeting was very positive. In particular, feedback was highly enthusiastic for the conference on implementation of NQF-endorsed™ measures that was held the day before. NQF has had requests from various parties (e.g., American Hospital Association, Federation of American Hospitals, National Rural Health Association) to convene similar meetings with slightly different foci (e.g., only hospitals or for rural healthcare). However, there is currently no funding to support these requests. The May 9, 2005, meeting was convened at the behest of the Centers for Medicare and Medicaid Services (CMS).

D. Governance. John O. Agwunobi, MD, MBA, was announced as the designee for appointment as Assistant Secretary for Health at the Department of Health and Human Services. U.S. Senate confirmation is pending.

Clyde Behney has been appointed to the Institute of Medicine liaison seat by Dr. Harvey Fineberg.

E. Financial. The Robert Wood Johnson Foundation (RWJF) has awarded NQF a $3 million endowment-like grant. An Investment Committee consisting of Paul H. O'Neill (Chair), Gerald M. Shea (Treasurer), and myself will oversee investment of the grant, pursuant to guidelines provided by RWJF.

The Agency for Healthcare Research and Quality (AHRQ) has awarded NQF $25,000 under a small conference grant for the 2005 Annual Meeting.

The Centers for Disease Control and Prevention (CDC) has awarded NQF an additional $144,000 for year 2 of activities related to the Institute for Quality Laboratory Management.

The original funders of the National Commission for Quality Long-Term Care have increased support for the Commission. The additional amount equates to approximately $200,000 in 2005, $600,000 in 2006, and $100,000 in 2007.

CMS has forwarded measures for end-stage renal disease quality of care in anticipation of funding a consensus development project in this area once it identifies a funding vehicle.

We continue to discuss the scope of a project with AHRQ related to its patient safety indicators. This is likely to be a slightly narrower scope than AHRQ's entire quality indicators set as previously requested and approved by the Board for expedited consensus in October 2004.

As an ancillary activity to the project to develop measures for prevention and treatment of venous thromboembolism (VTE) (previously referred to as the project on deep vein thrombosis), Sanofi-Aventis has approached NQF about convening a separate invitational conference on the issue. Discussions on the scope and nature of such a conference are ongoing.

The Association for Professionals in Infection Control and Epidemiology has provided $25,000 for an NQF project on infection control; additional discussions with other parties to fund the balance of the project are ongoing.

The field portion of the independent audit, conducted by Gelman, Rosenberg, and Freedman, took place April 4-8, 2005. The draft audit report will be reviewed at the meeting on October 7, 2005.

F. Program Updates.

National Framework and Preferred Practices for Palliative and Hospital Care
The Review Committee has concluded its work and a proposed draft framework; preferred practices are in the final stages of preparation for the review phase of the Consensus Development Process. We anticipate it will be launched just before or immediately after the Annual Meeting.

VTE Performance Measures
The Steering Committee and TAP held their initial meetings, and a second Call for Measures has been conducted by NQF and The Joint Commission. The Steering Committee will meet on December 19, 2005, to finalize its recommendations for practices

and policies for prevention, treatment, and diagnosis of VTE. The Joint Commission's measure development work is ongoing and will be considered by the Steering Committee next year.

Cancer Care Quality Measures

The project's Breast Cancer Steering Committee met on June 29, 2005, and considered 26 candidate consensus standards. A draft report is in the final stage of preparation for the review phase of the Consensus Development Process. We anticipate it will be launched just before or immediately after the Annual Meeting.

The Technical Panels (TPs) for the colorectal cancer and symptom management/end-of-life care priority areas met on September 14 and September 19, 2005, respectively. Both TPs are finalizing their recommendations to the Steering Committee, which will meet to consider them on December 1-2, 2005, in Washington, DC.

Institute for Quality Laboratory Management

As previously noted, CDC has provided additional funding of approximately $144,000 for the second year of the cooperative agreement. Combined with carryover funds from year 1, CDC has indicated it will request that NQF convene two workshops on various aspects of laboratory medicine quality.

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

The draft consensus report is out to NQF Members for voting; the ballot deadline is October 3, 2005. The Board will consider the results of the voting at the meeting on October 7, 2005.

Ambulatory Care Quality Measures

All four Member Councils approved 36 consensus standards on the first ballot, and the Board subsequently endorsed these during its conference call on August 3, 2005. Eight measures were not approved on the first ballot, six of which had specifications for "optional exclusions." Although the original recommendation approved by the Board was to consider the eight measures during Phase 3 of the project, the measure developer, i.e., the National Committee for Quality Assurance, agreed to adjust the specifications to make the exclusions mandatory for those six measures. The Executive Committee then approved a second round of voting, which concluded on September 21, 2005, and will be considered by the Board at its meeting on October 7, 2005.

Phase 3, Cycle 1 of the project has commenced. Cycle 1 encompasses measures for the following priority areas: asthma, coordination of care, hypertension,

medication management, obesity, and prevention. The Steering Committee met on August 15, 2005, to establish guidelines for the Technical Advisory Panels (TAPs) work, and the TAPs are now conducting in-person and/or conference calls to evaluate candidate consensus standards. The Steering Committee will meet on December 14-15, 2005, to consider the TAP's recommendations, and a draft consensus report for Cycle 1 measures will be available in early 2006.

Voluntary Consensus Standards for Adult Diabetes Care: 2005 Update

As approved by the Board on its August 3, 2005, conference call, the quality improvement-only and community measures were forwarded to Members for a second round of voting. The ballot deadline was September 16, 2005; the results will be considered by the Board at the meeting on October 7, 2005.

Patient Safety Taxonomy

The draft report recommending The Joint Commission's Patient Safety Event Taxonomy (PSET™) as a consensus standard was approved by all four Councils on the first ballot, and the Board endorsed the PSET on its conference call on August 3, 2005. One appeal was received from the Department of Veterans Affairs and will be considered by the Board at the meeting on October 7, 2005.

Implementation of NQF-Endorsed Voluntary Consensus Standards: National Conference

NQF has endorsed performance measure sets for the hospital, nursing home, and home health care settings, and has a major project underway to endorse consensus standards for ambulatory care. On May 9, 2005, NQF convened, at the behest of the CMS, a conference to identify opportunities and barriers to implementation of these measure sets. A meeting summary is being prepared.

Standardizing a Measure of Patient Experience (HCAHPS®)

The Board considered an appeal on its August 3, 2005, conference call. The appeal was denied, and the report is ready for final publication, but we have suspended the process pending a CMS notice in the *Federal Register* regarding whether it is proposing material changes to HCAHPS as a result of additional agency deliberations related to its cost-benefit analysis.

Home Health Performance Measures

The report is being printed and will be available shortly after the Annual Meeting.

Pay-for-Performance Programs: Guiding Principles and Design Strategies
The report is in the publishing phase, and we anticipate its availability shortly after the Annual Meeting.

Several Members have indicated strong support for NQF to undertake a consensus project on pay-for-performance program guiding principles and design strategies. The potential need for this is underscored by the multiple different sets of guiding principles for pay-for-performance programs promulgated by various organizations and our awareness of several more in development. We continue to explore funding opportunities for such a project.

Improving Safe Use of Prescription Medications
This project, funded by the California Endowment, identifies a "safe medication use framework" aimed at increasing the effectiveness of prescription medication use by patients, especially those with low health literacy and/or limited English proficiency. The report is being printed, and we anticipate it will be available by the Annual Meeting.

Evidence-Based Practices for Substance Abuse Treatment Workshop
On December 13, 2004, NQF convened a workshop, funded by RWJF, to i) identify a set of evidence-based treatments for substance use disorders that are widely recognized as being important components of effective treatment programs and ii) 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. The workshop summary is being printed, and we anticipate it will be available by the Annual Meeting.

Informed Consent and Patient Safety
This project, funded by the Commonwealth Fund, explored the implementation of NQF-endorsed Safe Practice 10 relating to informed consent for low literacy/ limited English proficient patients. A workshop to discuss the case studies and site visits, results of interviews of non-adopters, and the draft user's guide for implementation was held in September 2004. The proceedings and user's guide were published and disseminated to the Board and NQF Members in early September.

Cardiac Surgery Performance Measures
On August 8, 2005, UnitedHealth Group announced an initiative with the Society of Thoracic Surgeons (STS) and the American College of Cardiology (ACC) that will require hospitals seeking United Health Premium ™ to submit data to the STS database and the ACC registry, which both include information on NQF-

endorsed measures. We are contacting UnitedHealth to encourage them to publicly report information on the NQF-endorsed consensus standards.

Behavioral Health

The workshop proceedings have been printed and disseminated to the Board and NQF Members.

Safe Practices for Better Healthcare

The Safe Practices Maintenance Committee met by conference call, and it will hold an in-person meeting on September 30, 2005, in Washington, DC. NQF Members and the public were invited to submit new practices and/or recommend changes to the existing 30 NQF-endorsed practices (including exclusion of a practice). Results from this Call for Practices will be among the issues discussed by the Committee at its in-person meeting.

Serious Reportable Adverse Events in Healthcare

The "Never Events" Maintenance Committee was appointed and has met by conference call to discuss how to proceed with its work and to review the scope, definitions, and criteria established in the NQF-endorsed report. A call for comments on the original list of events (changes or deletions) and/or proposed new events closed on September 20, 2005. The Committee will consider material received from this solicitation, as well as hear from states that have implemented the list or are considering implementation, at an in-person meeting on October 5, 2005.

As noted in the previous report, recent interest in the implementation of the list of 27 events is increasing. Minnesota, Connecticut, and New Jersey have implemented the entire list and specifications by statute or regulation; Illinois has implemented 24 of 27 events and specifications; Texas has implemented at least 2 of 27 events and specifications; Georgia has implemented the event descriptions and categories; and Missouri has legislation pending to implement the list. Indiana and California recently expressed interest in implementing the list. The Department of Defense requires all TRICARE contractors to collect the events, as specified. Finally, the province of Saskatchewan, Canada, has implemented the list, with some additions.

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., The Joint Commission survey results), patient safety, liability/risk management, satisfaction (customer, patient, employee, provider), financial performance, efficiency, and personnel

development. A commissioned paper will review current knowledge about the broad hospital quality/performance reporting tools and be 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. Because executing an agreement with HCA has proved elusive, we are proceeding with the project with the funding provided by the Department of Veterans Affairs.

National Commission for Quality Long-Term Care
The Commission held its first public hearing on July 22, 2005, and heard from federal and state officials, researchers, providers, and consumer advocates. The hearing was well received, and the Committee will meet on September 26, 2005, in Executive Session to consider the testimony and to discuss its first report, which is currently targeted for delivery in December 2005-January 2006.

G. Outreach. An active outreach effort continues.

H. Miscellaneous.

The Ad hoc Advisory Committee on Evidence Grading was appointed and met by conference call on September 12, 2005, to review a draft grading and evaluation scheme prepared by NQF; a second call is scheduled for September 28.The status of the Committee's deliberations will be reported to the Board at the meeting on October 7, 2005.

The Ad hoc Advisory Committee on Performance Measure Criteria held a conference call on September 13, 2005, and a second conference call is scheduled for September 27. The status of the Committee's deliberations will be reported to the Board at the meeting on October 7, 2005.

A second Call for Nominations for the Voluntary Consensus Standard Maintenance Committees in the pulmonary and cardiac areas closed on September 26, 2005.

NQF has filed to trademark National Quality Forum, NQF-endorsed, and NQF.

NATIONAL QUALITY FORUM

MEMBERS

AARP
ABIM Foundation
ACC/AHA Task Force on Performance Measures
Accreditation Association for Ambulatory Health Care - Institute for Quality Improvement
ACS/MIDAS+
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Adventist HealthCare
Aetna
AFL-CIO
Agency for Healthcare Research and Quality
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America's Health Insurance Plans
American Academy of Family Physicians
American Academy of Nursing
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association of Colleges of Nursing
American Association of Homes and Services for the Aging
American Association of Nurse Anesthetists
American Association of Nurse Assessment Coordinators
American Board of Medical Specialties
American College of Cardiology
American College of Chest Physicians
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American College of Gastroenterology
American College of Medical Quality
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology
American College of Surgeons
American Federation of Teachers Healthcare
American Health Care Association
American Health Quality Association
American Heart Association
American Hospice Foundation
American Hospital Association
American Managed Behavioral Healthcare Association
American Medical Association
American Medical Group Association
American Nurses Association
American Optometric Association
American Osteopathic Association
American Pharmacists Association Foundation
American Psychiatric Institute for Research and Education
American Society for Quality - Health Care Division
American Society for Therapeutic Radiology and Oncology
American Society of Clinical Oncology
American Society of Health-System Pharmacists
American Society of Interventional Pain Physicians
Anesthesia Patient Safety Foundation
Ascension Health
Association of American Medical Colleges
Association of Professors of Medicine
Aurora Health Care
Bayhealth Medical Center
Baylor Health Care System
Beverly Enterprises
BJC HealthCare
Blue Cross Blue Shield Association
Bon Secours Health System
BoozAllenHamilton
Bristol Myers Squibb
Bronson Healthcare Group
Buyers Health Care Action Group
Calgary Health Region - Quality Improvement and Health Information
California HealthCare Foundation
Cancer Quality Council of Ontario
Cardinal Health
CareScience
Catholic Health Association of the United States
Catholic Health Initiatives
Catholic Healthcare Partners
Center to Advance Palliative Care
Centers for Disease Control and Prevention
Centers for Medicare and Medicaid Services
Central Florida Health Care Coalition
Centura Health
Child Health Corporation of America
CHRISTUS Health
CIGNA Healthcare
City of New York Department of Health and Hygiene
Cleveland Clinic Foundation
College of American Pathologists
Community Health Accreditation Program
Connecticut Hospital Association
Consumer Coalition for Quality Health Care
Consumers Advancing Patient Safety
Consumers' Checkbook
Coral Initiative
Council of Medical Specialty Societies
CRG Medical
Delaware Valley Society for Thoracic Surgeons Quality Improvement Initiative
Delmarva Foundation
Detroit Medical Center
Dialog Medical
District of Columbia Department of Health
eHealth Initiative
Eli Lilly and Company
Empire Blue Cross and Blue Shield
Employer Health Care Alliance Cooperative (The Alliance)
Employers' Coalition on Health
Exempla Healthcare
Federation of American Hospitals
First Consulting Group
First Health
Florida Hospital Medical Center
Florida Initiative for Children's Healthcare Quality
Ford Motor Company
Forum of End Stage Renal Disease Networks
General Motors
Gentiva Health Services
Good Samaritan Hospital
Greater Detroit Area Health Council
Greater New York Hospital Association
Hackensack University Medical Center
Harrington Memorial Hospital
HCA
Health Alliance of Mid-America
Health Care Compliance Strategies
Health Care Excel
Health Grades
Health Information Management Systems Society
Health Management Associates
Health Plus
Health Resources and Services Administration
Health Services Advisory Group
HealthCare 21
Healthcare Leadership Council
HealthHelp
HealthPartners
Henry Ford Health System
Hoag Hospital
Horizon Blue Cross Blue Shield of New Jersey
HR Policy Association
Hudson Health Plan
Illinois Department of Public Health
Illinois Hospital Association
Infectious Diseases Society of America
Institute for Clinical Systems Improvement
Institute for Safe Medication Practices
Integrated Healthcare Association

NATIONAL QUALITY FORUM

MEMBERS

Integrated Resources for the Middlesex Area
INTEGRIS Health
Iowa Foundation for Medical Care
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John Muir/Mt. Diablo Health System
Joint Commission on Accreditation of Healthcare Organizations
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Leapfrog Group
Lehigh Valley Business Conference on Health
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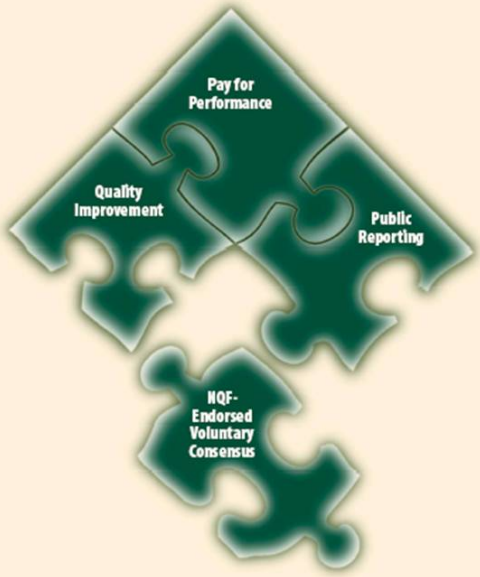
Loyola University Health System - Center for Clinical Effectiveness
Lumetra
Lutheran Medical Center
Maine Health Management Coalition
Maine Quality Forum
March of Dimes
Mayo Foundation
Medical Review of North Carolina
MedMined
MedQuest Associates
Medstat
Memorial Health University Medical Center
Memorial Sloan Kettering Cancer Center
Mercy Medical Center
The Methodist Hospital
Milliman Care Guidelines
National Academy of State Health Policy
National Association for Healthcare Quality
National Association for Home Care & Hospice
National Association Medical Staff Services
National Association of Chain Drug Stores
National Association of Children's Hospitals and Related Institutions
National Association of Public Hospitals and Health Systems
National Association of State Medicaid Directors
National Business Coalition on Health
National Business Group on Health
National Citizen's Coalition for Nursing Home Reform
National Coalition for Cancer Survivorship
National Committee for Quality Assurance
National Committee for Quality Health Care
National Consensus Project on Quality Palliative Care
National Family Caregivers Association
National Hospice and Palliative Care Organization
National Institutes of Health
National Partnership for Women and Families
National Patient Safety Foundation
National Research Corporation
National Rural Health Association
Nebraska Heart Hospitals
Nemours Foundation
New England Healthcare Assembly
New Jersey Health Care Quality Institute
New York Presbyterian Hospital and Health System
Niagara Health Quality Coalition
North Carolina Baptist Hospital
North Shore - Long Island Jewish Health System
North Texas Specialty Physicians
Northeast Health Care Quality Foundation
Norton Healthcare
Oakwood Healthcare System
Ohio KePRO
OmniCare
Online Users for Computer-assisted Healthcare
Pacific Business Group on Health
PacifiCare
PacifiCare Behavioral Health
Parkview Community Hospital and Medical Center
Partners HealthCare
Partnership for Prevention
Pennsylvania Health Care Cost Containment Council
Pfizer
Physician Consortium for Performance Improvement
Premier
Press, Ganey Associates
Professional Research Consultants
ProHealth Care
Research!America
Robert Wood Johnson Hospital - Hamilton
Robert Wood Johnson University Hospital - New Brunswick
Roswell Park Cancer Institute
sanofi-aventis
Schaller Anderson
Select Quality Care
Sentara Norfolk General Hospital
Service Employees Industrial Union
Sisters of Charity of Leavenworth Health System
Sisters of Mercy Health System
Society for Healthcare Epidemiology of America
Society of Critical Care Medicine
Society of Thoracic Surgeons
Solucient
South Central Michigan Health Alliance
Spectrum Health
St. Louis Business Health Coalition
St. Mary's Hospital Medical Center
St. Vincent Regional Medical Center
State Associations of Addiction Services
State of New Jersey Department of Health and Senior Services
State University of New York - College of Optometry
Sutter Health
Tampa General Hospital
Tenet Healthcare
Texas Medical Institute of Technology
Triad Hospitals
Trinity Health
Uniform Data System for Medical Rehabilitation
United Hospital Fund
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 North Carolina - Program on Health Outcomes
University of Pennsylvania Health System
University of Texas-MD Anderson Cancer Center
URAC
US Department of Defense - Health Affairs
US Food and Drug Administration
US Office of Personnel Management
US Pharmacopeia
UW Health
Vail Valley Medical Center
Value Options
Vanguard Health Management
Veterans Health Administration
VHA
Virginia Cardiac Surgeons Quality Initiative
Virginia Health Quality Center
Washington State Health Care Authority
Waukesha Elmbrook Health Care
WellPoint
West Virginia Medical Institute
Wisconsin Collaborative for Healthcare Quality
Yale New Haven Health

THE ACCOUNTABILITY AND TRANSPARENCY PUZZLE: IMPLEMENTING NQF-ENDORSED CONSENSUS STANDARDS



NATIONAL QUALITY FORUM
6TH ANNUAL MEETING
OCTOBER 6 & 7, 2005

AHRQ Agency for Healthcare Research and Quality

NQF National Quality Forum

THE NATIONAL QUALITY FORUM

THE ACCOUNTABILITY AND TRANSPARENCY PUZZLE: IMPLEMENTING NQF-ENDORSED CONSENSUS STANDARDS

Thursday, October 6

8:00 am CONTINENTAL BREAKFAST

8:30 am WELCOME AND OPENING REMARKS
Kenneth W. Kizer, MD, MPH, President and CEO, National Quality Forum

8:45 am MORNING PLENARY
The Honorable Michael O. Leavitt, US Dept of Health and Human Services

9:30 am PREPARING FOR PAY FOR PERFORMANCE
MODERATOR: **Katherine Browne**, Ntl Partnership for Women and Families
Stephen Grossbart, PhD, Catholic Healthcare Partners, Implementation and Improvement: The Effects of Implementing National Quality Forum Voluntary Consensus Standards Across a Multi-hospital System
Daniel W. Varga, MD, Norton Healthcare, Implementing ALL the Consensus Standards: The Journey So Far
Janet Davis, MS, RN, Tampa General Hospital, National Quality Forum's Nursing-Sensitive Care Measures: Bringing It to the Bedside
Q & A

10:30 am BREAK

10:45 am MEASURING EFFICIENCY
MODERATOR: **Benjamin Eng, MD**, Pfizer
Barry Straube, MD Centers for Medicare & Medicaid Services
Margaret O'Kane, National Committee for Quality Assurance
Bernard Kershner, AAAHC-Institute for Quality Improvement
Mark Rattray, MD, United Healthcare Premium Designations Program
RESPONDENT: **Kaveh Safavi, MD, JD**, Solucient

12:00 pm LUNCH PLENARY

1:15 pm FOCUS ON PRIORITY AREAS
MODERATOR: **Rita Munley Gallagher, PhD**, American Nurses Association
Michael O'Toole, MD, ACC/AHA Task Force on Performance Measures, Implementation of NQF-endorsed Ambulatory Care Measures for Coronary Artery Disease, Heart Failure and Hypertension
David S. Wong, MD, MSc, American Academy of Orthopaedic Surgeons, Implementing the NQF Patient Safety Taxonomy in Orthopaedics
Yosef D. Dlugacz, PhD, North Shore-Long Island Jewish Health System, Proof in the Evidence!
Q & A

Thursday, October 6 (continued)

2:15 pm STATES, SYSTEMS AND COLLABORATIVES GET IN THE ACT
MODERATOR: **Steve Wetzell**, HR Policy Association
Dennis Shubert, MD, PhD, Maine Quality Forum, State Perspectives on Implementation of National Voluntary Consensus Standards
Mike Kern, MD, John Muir/ Mt. Diablo Health System, Across the Continuum at John Muir/ Mt. Diablo Health System: Implementing NQF Measures to Improve Quality for Our Patients
Caron Lee, Institute for Clinical Systems Improvement, Implementation of NQF Guidelines for Diabetes Care and Patient Safety Through Quality Improvement Collaboratives
Q & A

3:15 pm BREAK

3:30 pm PAY FOR PERFORMANCE PROGRAMS
MODERATOR: **Jeffrey Rich, MD**, Virginia Cardiac Surgery Initiative
Karen Davis, PhD, The Commonwealth Fund
Meredith Rosenthal, PhD, Harvard University
Andrew Webber, National Business Coalition on Health
Arthur Levin, Center for Medical Consumers
Q & A

4:45 pm PRESENTATION OF JOHN M. EISENBERG PATIENT SAFETY AND QUALITY AWARDS
Dennis S. O'Leary, MD, JCAHO
Kenneth W. Kizer, MD, MPH, President and CEO, National Quality Forum

5:15 pm RECEPTION

Friday, October 7*

8:00 am CONTINENTAL BREAKFAST

8:30 am MEMBER COUNCIL BUSINESS MEETINGS—**NQF MEMBERS ONLY**
Consumer Council
Health Professional, Provider and Health Plan Council
Purchaser Council
Research and Quality Improvement Council

12:00 pm WORKING LUNCH—**NQF MEMBERS ONLY**

1:00 pm BOARD OF DIRECTORS MEETING
Council reports
Other business

4:30 pm ADJOURN

* These times may vary and are dependent on the Board's Executive Session.