NATIONAL QUALITY FORUM

Memo

May 10, 2013

TO: NQF Board of Directors

FROM: Larry Becker and Frank Opelka, Consensus Task Force Co-Chairs

RE: Update on Consensus Task Force and CDP Improvement

Background

The Board approved a task force in August 2012 that would review and recommend options for defining and achieving consensus within NQF's consensus development process. The charge to the Consensus Task Force (CTF):

1) Review different approaches to establishing consensus;
2) Identify the strengths and weaknesses of the current process; and
3) Recommend enhancements to the current process.

As part of this work, the Task Force sought input from NQF members on their concerns with the current process and defining consensus and suggestions for improvement through five focus groups. The CTF considered different models used by other consensus based standard-setting organizations as well as multiple models that emerged from a staff lean event in January 2013. The proposed model was discussed with the CSAC at their March in-person meeting. Board members and council leadership had an opportunity to provide early input to the proposed redesign of the process. In April, the CTF considered feedback from the CSAC and others on the proposed CDP redesign. In summary, there was strong support for proposed changes related to the efficiency of the CDP, but less support for changes related to consensus. The CTF agreed to proceed immediately with process redesigns related to efficiency and with those incremental efforts to achieve consensus that have garnered broad support to date. It also agreed with staff recommendations to proceed with small tests of change to demonstrate effectiveness of the process changes.

The recommended modifications included:

Efficiency Goals:

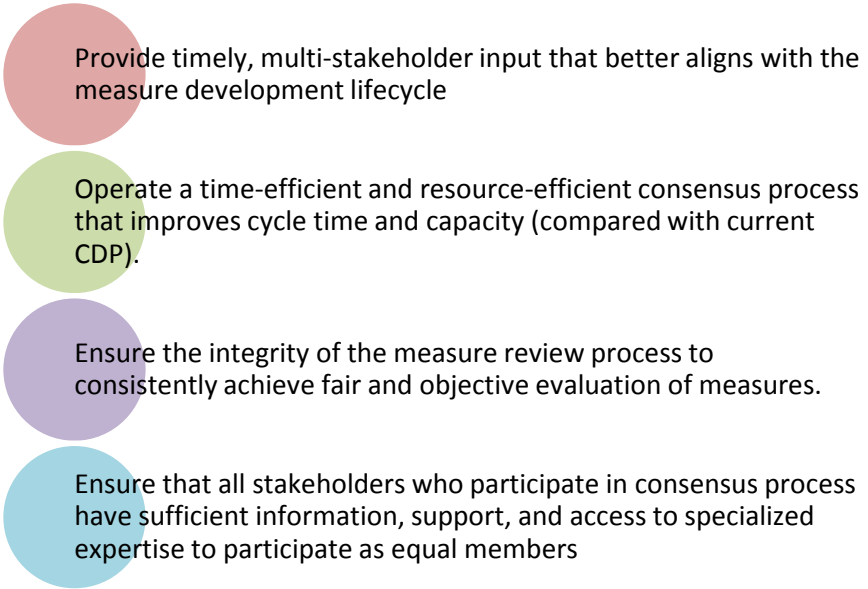
- Move from ad hoc Steering Committees to Standing Committees in order to enable the following:
- Reduce project start-up time
- Reduce time between measure submission and measure review
- Move to single flow processing of measures

- Utilize technical review/blinded peer reviewers to provide input on evidence and testing of the measures to the Standing Committee
- Enhance the ability of Consumers/Purchasers to serve as effective Steering Committee members, ensuring the voice of the patient is not lost
- Enhance the current CDP process to best enable contributions from all Steering Committee members during measure evaluation discussions (e.g., facilitation, training)
- Address the need for NQF member and public input prior to endorsement recommendation

Consensus Goals:

- Establish when consensus has been reached and developing an approach to establish quorums and thresholds for approval of measures within the current CDP process
- Develop a process for additional deliberation when it is unclear whether consensus has been reached

To realize these goals, NQF staff worked in four 4 lean teams and rapidly defined aims, principles, problem statements and recommended implementation approaches that would be achievable within the current NQF budget. To date, the lean teams have developed their project plans, including problem statement, scope, principles, assumptions, and potential solutions. The ideal state aims include the following:



The Consensus Task Force reviewed the lean redesign work to date, along with projected impact and level of effort for each of the solutions. The prioritized CTF recommendations were reviewed the projected impact and level of effort for each of the solutions (Appendix A).

Next steps

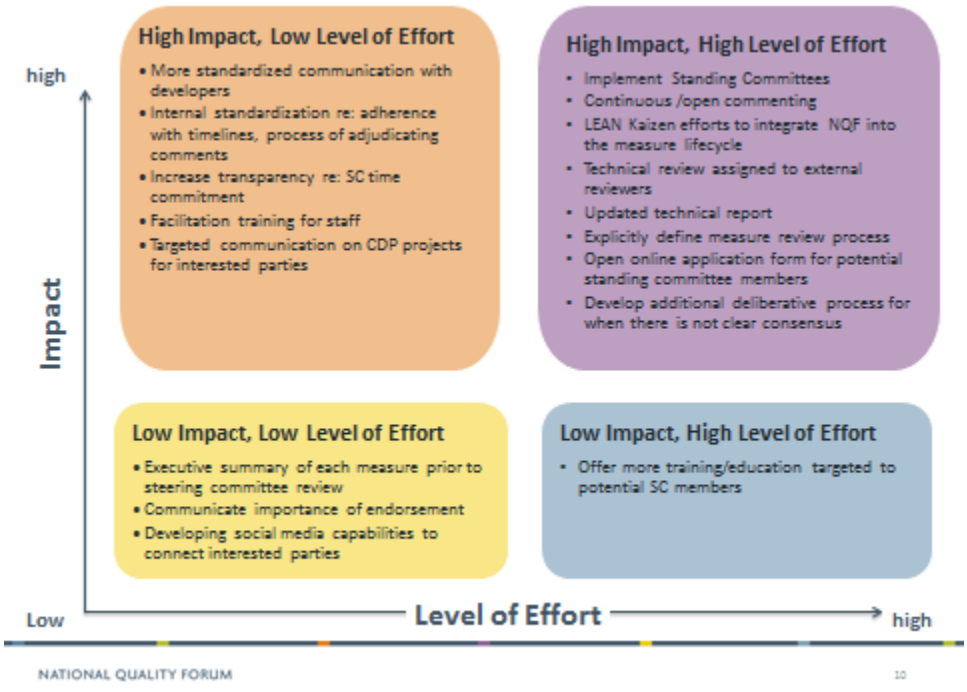
In the next phase of CDP lean Improvement that will begin mid-May, the lean teams will develop implementation plans for each prioritized potential solution; demonstrate how the proposed

solution will be tested, communicated, and analyzed; and consider how the prioritized potential solutions can undergo small tests of change within upcoming CDP projects over this summer. In addition, each team will develop a communication plan for staff and external stakeholders that will include a broad education strategy.

Given the need to further consider balance of interest at the Board level, consensus redesign efforts will focus on incremental approaches to establishing consensus. NQF will continue to work with ONC and CMS on a Kaizen event that would explore opportunities for greater alignment and integration between measure development and endorsement. A new Task Force on Measure Evaluation will be formed that will review problems observed with measure submission and evaluation (particularly related to evidence, reliability and validity testing), identify causes, and propose potential solutions. This work will be closely aligned with ongoing work on the integrity of the review process. On a parallel track, NQF is working to consider more collaborative models to catalyze gap filling.

An update will be provided to the Board in September 2013.

Appendix A: Prioritized Solutions by Impact and Level of Effort



NQF Board Update: Consensus Task Force and CDP Update

NATIONAL QUALITY FORUM

Objectives

- Provide an update to the Board on the Consensus Task Force discussions
- Present recommendations and timeline for prioritized improvements
- Consider the work on CDP lean redesign in the broader context of CDP improvement and NQF's role in the measure pipeline

Consensus Task Force

- Review different approaches to establishing consensus;
- Identify the strengths and weaknesses of the current process;
- Recommend enhancements to the current process.

Background

August 2012

Consensus Task Force (CTF) established

October 2012

Focus groups conducted

November 2012

CTF reviews different approaches used by other standard setting organizations

Jan – Feb 2013

CTF considers models to achieve consensus developed through staff lean event

Background

March 2013

CTF proposed model shared with the CSAC and Board members

April 2013

CTF recommends proceeding with improvements related to efficiency and consensus

April – May 2013

NQF lean improvement teams rapidly define goals, problem statements, solutions, and metrics

May 2013

CTF reviews proposed solutions and prioritizes next steps

CSAC Input: Strong support for efficiency enhancements through rapid-cycle testing, rather then a wholesale change to the CDP

External Concerns with the CDP Process

- Focus group input centered on three themes:
  - Process Transparency and Consistency
  - Member Engagement
  - Balance of Interests
- Specific concerns with the CDP process:
  - Inconsistency in measure reviews
  - Long wait for measure submission opportunity
  - Lag to project starts
  - Right expertise not always at the table
  - Sunk investment by submission to NQF
  - Limited guidance to transition to eMeasures

Applying LEAN Improvement Techniques to The Problem

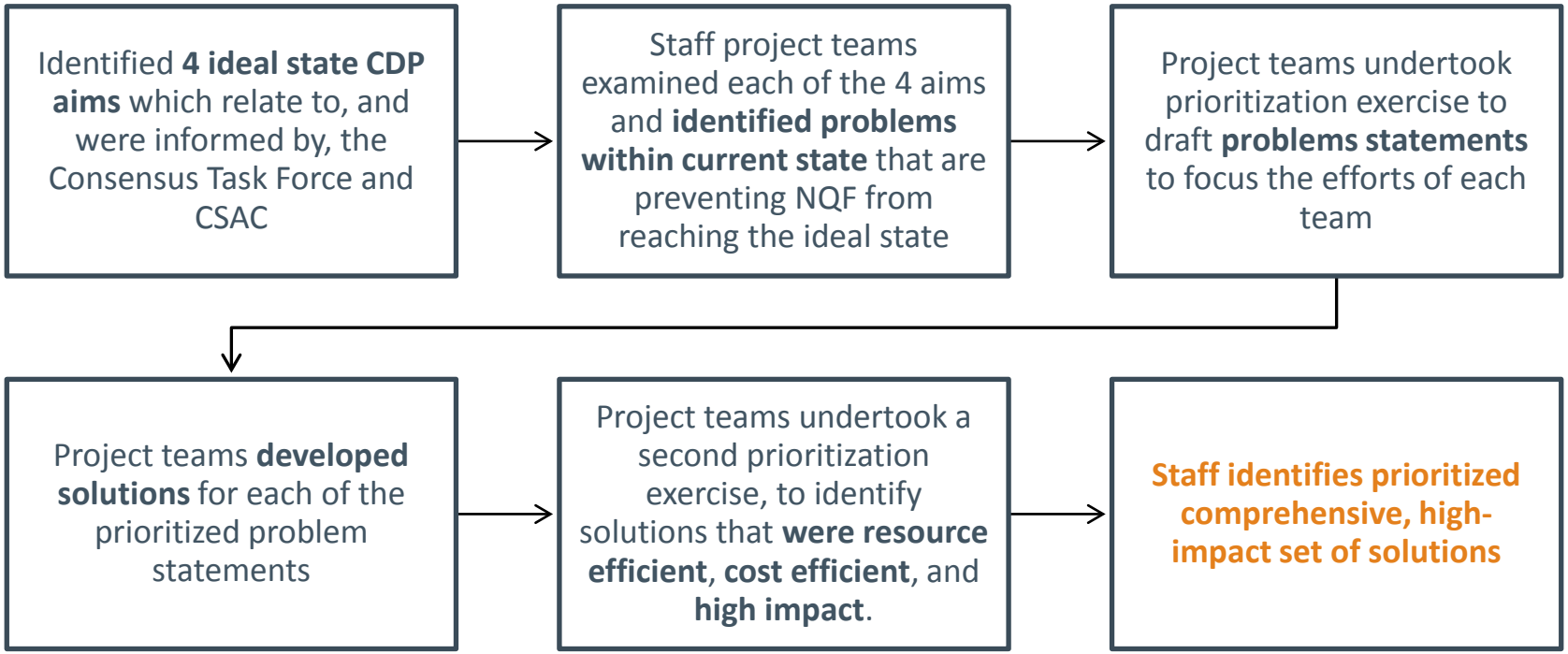
CDP Lean Improvement

Work is underway to rapidly define aims, principles, problem statements, recommended implementation approaches, and develop metrics.

Principles for the LEAN Effort

1. Balance the interests of members, users, measure developers, and funders and incorporating their input throughout the process
2. Ensure that no change to the CDP compromises the quality of the measure consensus development process outputs
3. Ensure that any individual process improvement does not contradict other changes in this redesign; any improvements should take into consideration other CDP changes, as appropriate
4. Ensure that process improvements are feasible given constraints of resources

CDP LEAN Improvement Process Map



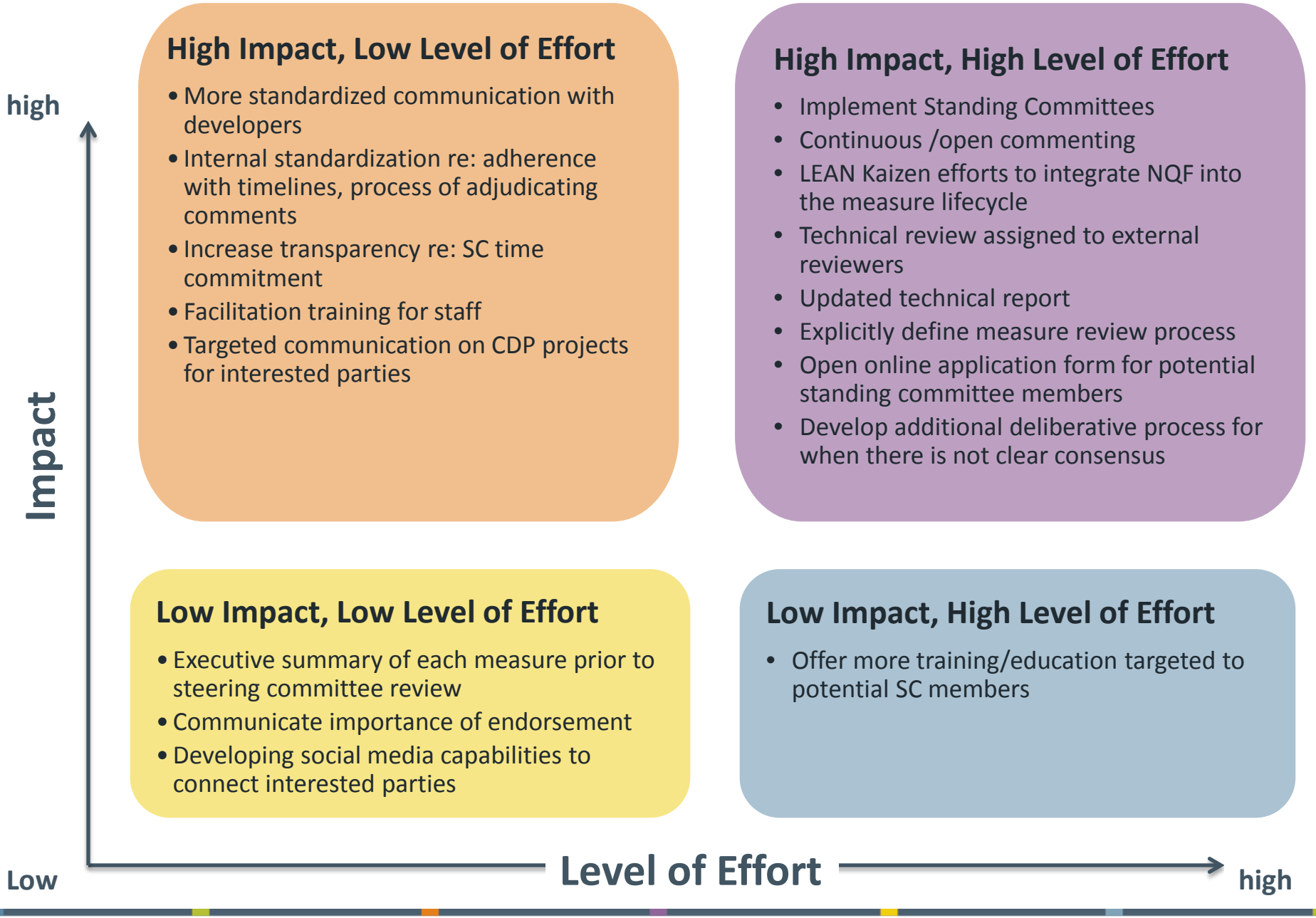
Ideal State Aims (Solutions)

- Provide timely, multi-stakeholder input that better aligns with the measure development lifecycle
- Operate a time-efficient and resource-efficient consensus process that improves cycle time and capacity (compared with current CDP).
- Ensure the integrity of the measure review process to consistently achieve fair and objective evaluation of measures.
- Ensure that all stakeholders who participate in consensus process have sufficient information, support, and access to specialized expertise to participate as equal members

Prioritizing Solutions

Impact vs. Level of Effort

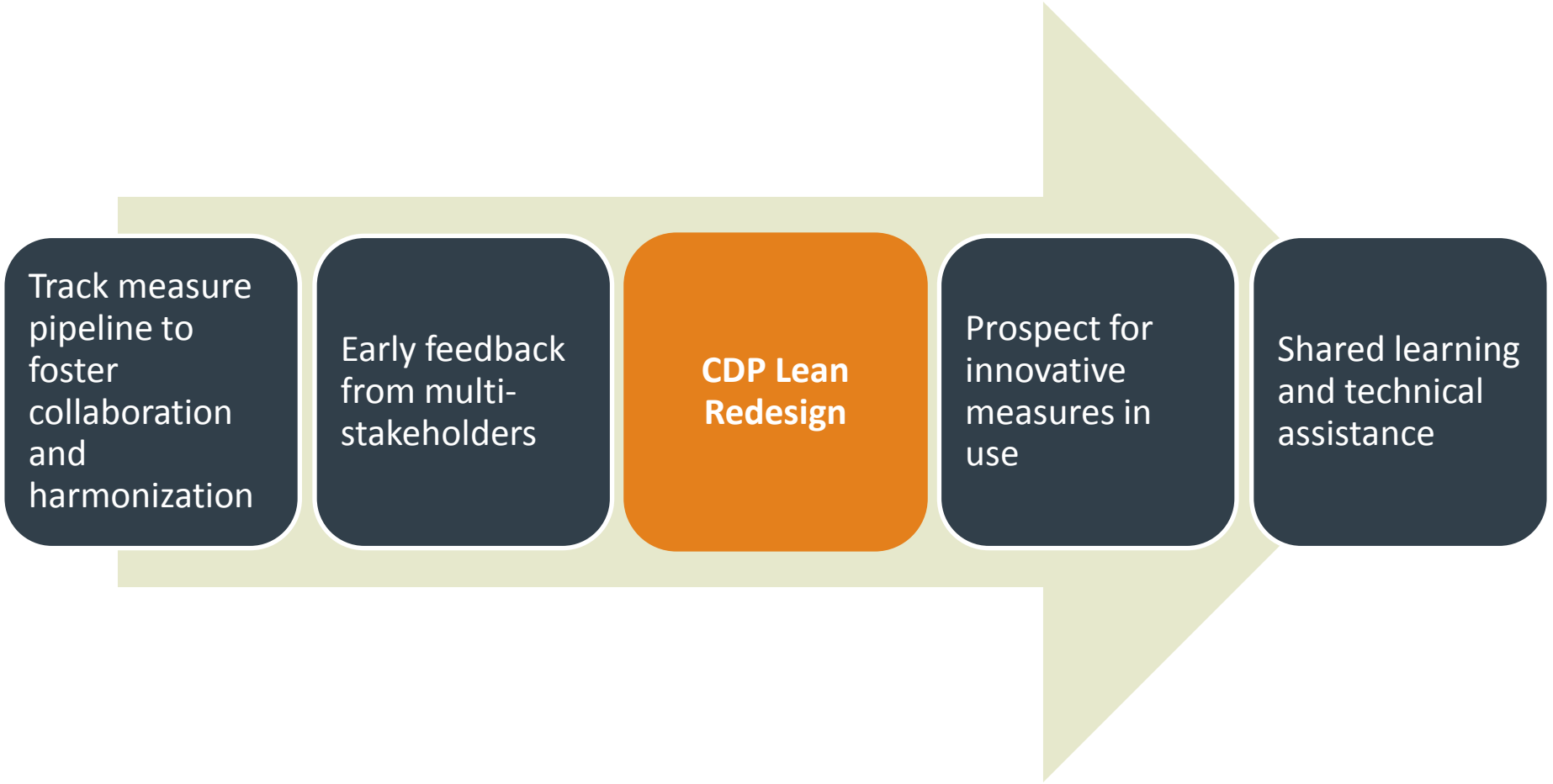
- Impact
  - Identifies the likely impact to external stakeholders, once the solution is fully implemented
- Level of Effort
  - Identifies the activities required to support efforts for implementing solutions (e.g., resources, staff effort to develop materials and processes, education, time, IT and communication needs)
  - All activities are achievable within current budget


High Impact, Low Level of Effort
• More standardized communication with developers
• Internal standardization re: adherence with timelines, process of adjudicating comments
• Increase transparency re: SC time commitment
• Facilitation training for staff
• Targeted communication on CDP projects for interested parties
High Impact, High Level of Effort
• Implement Standing Committees
• Continuous /open commenting
• LEAN Kaizen efforts to integrate NQF into the measure lifecycle
• Technical review assigned to external reviewers
• Updated technical report
• Explicitly define measure review process
• Open online application form for potential standing committee members
• Develop additional deliberative process for when there is not clear consensus
Low Impact, Low Level of Effort
• Executive summary of each measure prior to steering committee review
• Communicate importance of endorsement
• Developing social media capabilities to connect interested parties
Low Impact, High Level of Effort
• Offer more training/education targeted to potential SC members
high
Impact
Low
Level of Effort
high

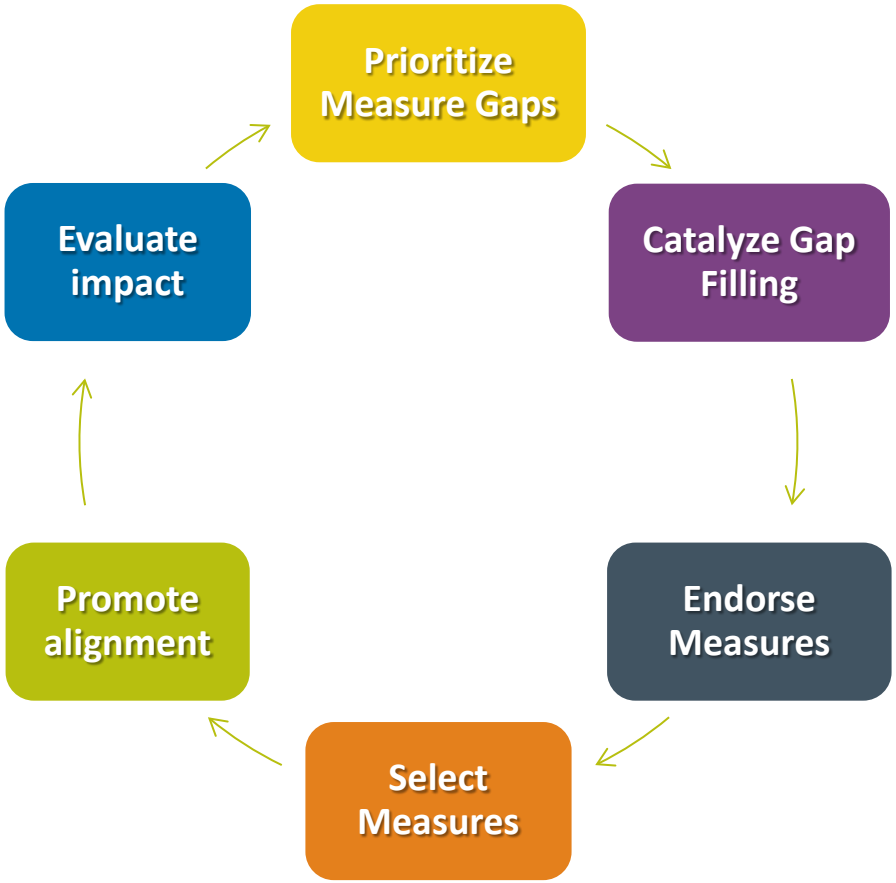
Next Steps

- Phase II work for CDP LEAN Improvement will begin mid-May.
  - During this next period, the teams will develop implementation plans for each prioritized potential solution.
    - » Within these plans, project teams will need to demonstrate how the proposed solution will be tested, communicated, and analyzed.
    - » In addition, each team will develop a communication plan for staff and external stakeholders that will include a broad education strategy.
- Progress report at Board meeting in September 2013

CDP Lean Redesign is Only One Part of NQF's Proposed Collaborative Role in the Measurement Pipeline



Collaborative Roles in Measurement



Key Roles for NQF

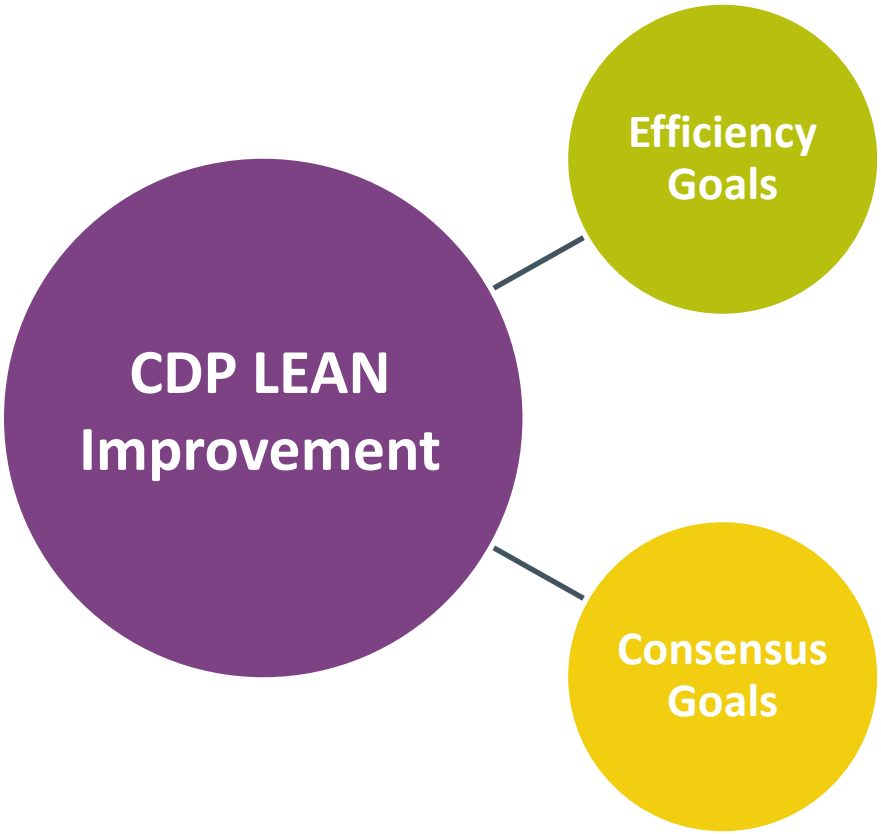
- Catalyze measurement gap filling through collaborative "incubator" role in the measurement pipeline.
- Reengineer the multi-stakeholder consensus process to meet emerging needs (e.g., single flow processing).
- Collaborate with broad set of HIT and measurement stakeholders, including EHR vendors on eMeasures.
- Promote alignment between public and private purchasers.
- Assess impact through systematic data collection on the use and usefulness of measures (e.g. open commenting on all endorsed measures in QPS)

Meet Evolving Needs

- Consider opportunities to “interdigitate” measure development and endorsement (e.g., CMS/ONC/NQF Kaizen)
- New task force will consider issues with measure evaluation and proposed solutions (e.g., consider tiered endorsement, eMeasure testing approaches)
- Provide expert guidance and a pathway forward on emerging measurement issues (e.g., PROs, SES)
- Partner and support emerging measurement approaches (e.g., registries, eMeasurement) to build toward reliable and evidence-based accountability measures.

APPENDIX

Goal—Solution Mapping



- Standing Committees
- Technical Review
- Enhance consumer/ purchaser voice
- Enhance SC contributions during meetings
- Early member and public comment

- Deliberative process
- Define consensus in CDP

Aim 1: Provide timely, multi-stakeholder input that better aligns with the measure development lifecycle

Problems

1. NQF needs to better understand and align with the measure development lifecycle
2. Misalignment of NQF's measure endorsement process with the measure development lifecycle results in inefficient use of developer and NQF resources.
3. Unclear understanding of how NQF guidance is beneficial to measure developers, users of measures, and those being measured.

Solutions

1. NQF is planning a Kaizen event between NQF, CMS/ONC, and other external stakeholders (e.g., measure developers) to identify areas in the measure development lifecycle where NQF could provide input.
2. Create ongoing opportunities for measure developer engagement with NQF to facilitate shared learning.
3. Create additional benefits and make benefits of NQF endorsement transparent.

Aim 2: Operate a time-efficient and resource-efficient consensus process that improves cycle time and capacity (compared with current CDP).

Problems

1. NQF does not solicit stakeholder and public comment at points in the process when it would be most useful.
2. The upfront time to seat each project's steering committee is time-intensive and requires significant staff resources.
3. Topic specific projects on 3-year cycles limit our flexibility to begin reviewing measures soon after measures are submitted for endorsement.
4. The measure review process requires stakeholders to undertake a heavy workload, provides them with inadequate education, and results in low engagement.

Solutions

1. Allow open comments on endorsed measures at any time, and commenting on newly submitted measures during the measure review period
2. Implement Standing Committees
3. Availability of Standing Committees with set meeting times (e.g. monthly) allowing for more frequent opportunities for measure submission evaluation
4. Provide a concise summary (e.g. 'executive summary') of each measure for Committee review to facilitate measure evaluation prior to meeting. NQF staff would provide the summary in a standardized template with links to measure detail

Aim 3: Ensure the integrity of the measure review process to consistently achieve fair and objective evaluation of measures.

Problems

1. There is no clear process defined for how to incorporate comments meaningfully into the measure evaluation

2. NQF does not have a defined process for meetings that ensures consistent measure evaluation and participation from SC members

Solutions

1. Staff develops standard work to address the need for internal standardization with regard to adherence with timelines, process of adjudicating comments (i.e. addressing each comment individually, follow-up etc.)

2. Train staff as facilitators for meetings, webinars, and conference calls
3. Offer more training/educational opportunities to those who wish to serve on committees/panels.
4. Initial measure evaluation should be completed by NQF staff; staff to provide steering committees with standardized summaries to aid them in making an informed decision.

Aim 3: Ensure the integrity of the measure review process to consistently achieve fair and objective evaluation of measures.

Problems

3. There are exceptions to the NQF measure evaluation process where the rationale is not transparent both externally and internally

Solutions

5. Explicitly define CDP, particularly measure review process.
6. Limit exceptions and develop alternative path for problems.
7. Refine and update developer guidebook to explain process.

Aim 4: Ensure that all stakeholders who participate in consensus process have sufficient information, support, and access to specialized expertise to participate as equal members

Problems

1. NQF communication to membership is not well targeted to their areas of interest, resulting in inconsistent inputs into the CDP

Solutions

1. More publicity earlier on in CDP projects (i.e. press releases at project launch; increased outreach throughout the CDP project)
2. Include more relevant information in technical reports (i.e. including language regarding why measures are important to different stakeholders; why endorsement is important, etc.)
3. Project list serve—sign up on project page to get updates

Aim 4: Ensure that all stakeholders who participate in consensus process have sufficient information, support, and access to specialized expertise to participate as equal member

Problems

2. We do not differentiate the knowledge and communication needs of different stakeholders (paired with internal knowledge gap)

Solutions

4. Education: for staff on project topic, for non-clinical SC on project topic, for members on how to participate
5. Why endorsement is important, what does it mean: information on site, in reports, on project pages, etc.
6. More standardized communication with developers
7. Predigest measures/provide measure summary/ do more in-house review of measures before providing them to SC, posting, etc.

Aim 4: Ensure that all stakeholders who participate in consensus process have sufficient information, support, and access to specialized expertise to participate as equal member

Problems

3. Process for vetting of steering committee members does not result in committees with the appropriate expertise needed for CDP project

Solutions

8. Better grouping of measures/smaller projects/phases with different SC members
9. Special experts for 1-2 measures if there are single measures on a sub topic (not TEP, full member)
10. Application form to have pool of potential SC members on hand
11. Remove member preference for seating on SCs

Aim 4: Ensure that all stakeholders who participate in consensus process have sufficient information, support, and access to specialized expertise to participate as equal member

Problems

4. NQF currently does not set clear expectations of steering committee members and NQF members at large

Solutions

12. Include much more detail about time requirement in call for nominations, SC introductory material, etc.
13. Education on how to participate, what it takes to be a good SC member or NQF member
14. Member poll—who is interested in topics, who wants to participate on projects (e.g., declare interest in voting)

Launching a New Member Engagement Program

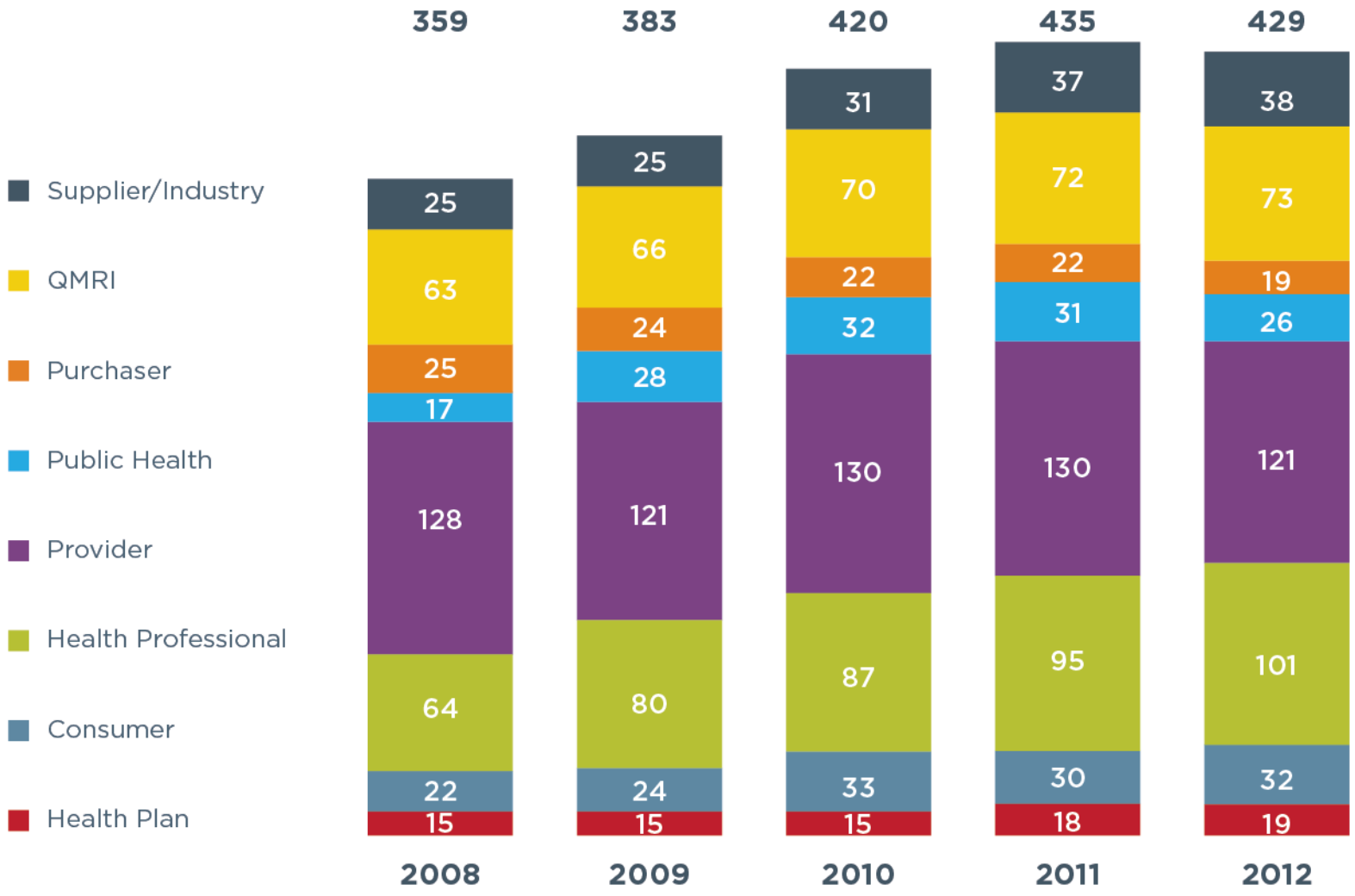
NATIONAL QUALITY FORUM

May 10, 2013

"NQF needs to prioritize and simplify its communications and efforts. I find it all overwhelming and difficult to participate. **My organization has doubts about the ongoing value of our participation.**"

“I feel NQF, like many governmental organizations, represents one more "old-boys" network that, if you're not in, you're out.”

Number of Members by Council



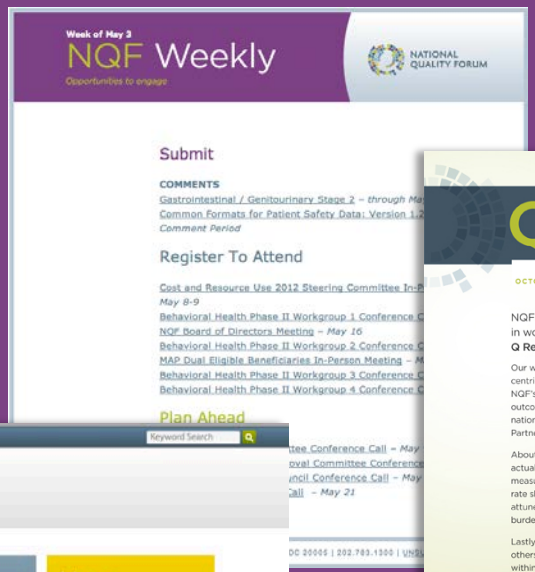
NUMBER OF MEMBERS VOTING OVER THE PAST YEAR

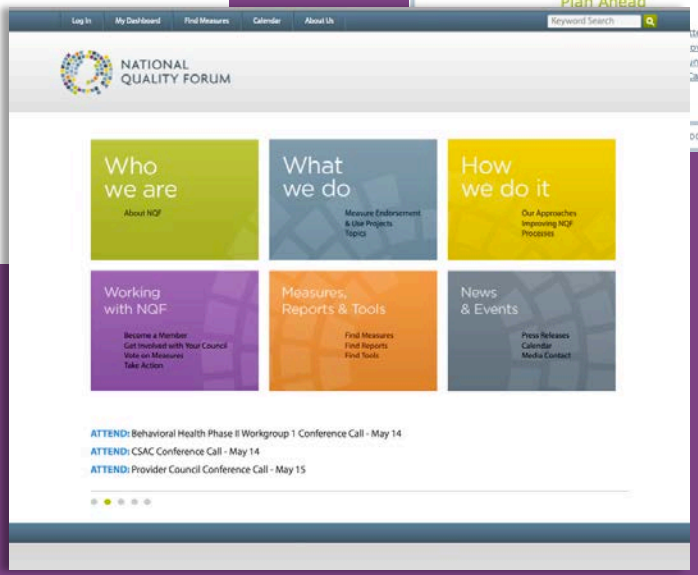
26 VOTES — Perinatal and Reproductive Health, April 2012

19 VOTES — Healthcare Disparities and Cultural Competency, August 2012

13 VOTES — Cancer Phase 2, October 2012

IMPROVING MEMBER COMMUNICATIONS—2012





I liked the interactivity of the sessions —keep it up!

Overall great conference given some of the leadership changes taking place. It was loud and clear that NQF wants to collaborate more... and the candor is appreciated.

Cross-departmental staff planning team

Objective—Produce a revamped approach to membership recruitment, retention, and engagement in the long term in order to:

- Better engagement of members to meet their needs
- Position NQF to rapidly grow its membership

SHORT-TERM DELIVERABLES

Stronger role for council leadership

- Bi-monthly council leader calls to set common agenda items for individual council calls
- Semi-annual in-person report to Board by Council leader
- *Launched April 2013*

SHORT-TERM DELIVERABLES

Project kick-off alert

- One-page template offering simple explanation of projects at kick-off, including relevance to members, how organizations can get involved, and key dates
- *Target launch date: May 2013*

SHORT-TERM DELIVERABLES

Members-only online graphics library

- Access to existing NQF materials—such as charts, tables, and images—to use in members' own work
- *Target launch date: May 2013*

SHORT-TERM DELIVERABLES

Members-only shared space on NQF website

- for members to share press releases, job postings, and other newsworthy information
- *Target launch date: June 2013*

SHORT-TERM DELIVERABLES

Development of logo use policy for members

- allow members to display affiliation with NQF, which is an increasingly common request
- *Target launch date: June 2013*

SHORT-TERM DELIVERABLES

Staff liaison program

- "go-to" staff person for member questions or requests
- help members guide their experience based on their interests
- *Target launch date: pilot program in June 2013*

INTERMEDIATE DELIVERABLES

New member orientation program

- Introduction to and education on NQF and the quality world. Material will be tiered based on member knowledge and experience.
- *Target launch date:*
  soft launch by July/August 2013

Is this plan on target?

What else should NQF do?

NATIONAL QUALITY FORUM

Board Update: 2013 National Priorities Partnership Strategic Planning

The National Priorities Partnership (NPP) held a strategic planning meeting on March 28, 2013 to review and define its role in advancing the National Quality Strategy (NQS), focusing heavily on how partner organizations can and should serve as leaders in supporting the alignment of public and private sector drivers—e.g., payment, public reporting, certification, accreditation and regulation, consumer incentives, and benefit designs—to expedite improvement.

2013 Survey of NQF Membership Progress on the NQS

NPP's strategic planning discussion was informed by an NQF survey of its 450 members to better understand the level of effort dedicated to advancing the priorities and goals of the NQS as well as results achieved (see attachment). Overall, respondents indicated active support for all areas of the NQS, although the intensity of engagement and range of results varied by priority area. The survey reflected the highest level of effort focused on patient safety and communication and care coordination. The lowest level of effort was focused on the health and well-being priority area. Respondents were asked to indicate whether they were achieving ongoing sustainable results. Again, patient safety reflected the highest level of results, and health and well-being the lowest. Survey respondents expressed an interest in working collaboratively on the NQS priorities, particularly on care coordination and person- and family-centered care and identified specific barriers related to data issues, local community needs, and competing priorities.

Through this survey, NQF has better knowledge of how its membership is working to achieve the NQS as well as its needs for making additional progress. A similar process for NPP could help to elucidate critical barriers that NPP could collectively and collaboratively seek to address.

2012 Efforts in Driving Action and Alignment

NPP partners agreed that they should continue to play a leadership role in building relationships to further alignment and accelerate change, and acknowledged the importance of the public and private sectors continuing to work concurrently and collaboratively to ensure alignment of efforts.

In 2012, NPP focused heavily on this role in the patient safety priority area by prototyping multistakeholder task forces ("action teams") to develop and execute plans for action by creating forums to share ideas and barriers and work on solutions to expedite progress. Partnership for Patients Co-Directors Dennis Wagner and Dr. Paul McGann highlighted results of the initiative and expressed an excitement and appreciation for NPP's role, particularly the action teams. They credited the Maternity Action Team for rapid improvement in reducing early elective deliveries in hospitals nationwide, and also noted the impact of the Readmissions Action Team and the Online Action Registry to accelerate progress.

NPP's Role Moving Forward

Building on this work in the patient safety priority area, partners expressed interest in expanding NPP's role in driving action as "effector arms" through current and new action teams, using the action team prototype to guide their work. The action team mechanism affords NPP an opportunity to identify short-term opportunities for focused action around which to develop goals, identify and prioritize barriers, identify practical policy drivers to resolve them, and rapidly, collectively, and collaboratively execute on solutions.

NPP partners discussed opportunities to advance each of the NQS priority areas, at various levels of care through several stakeholder perspectives. Nancy Wilson, Agency for Healthcare Research and Quality, spoke to the ongoing need for NPP to leverage public-private sector partnership to implement the NQS through coordinated action. She challenged the partners to think broadly about the best ways to move forward on all the NQS priorities as not all will be able to have a major initiative associated with them such as Partnership for Patients or Million Hearts. She encouraged NPP to build on the policies and infrastructure needs identified in the NQS, and to identify the most critical policy drivers to achieve the goals specified for each of the NQS six priority areas—and most importantly take action to align them.

Listening to Members

NATIONAL QUALITY FORUM

MONITORING PROGRESS OF THE NQS

In February 2013, National Quality Forum (NQF) surveyed its membership of 450 organizations around activities they were undertaking to advance the priorities and goals of the National Quality Strategy (NQS). Survey respondents represented organizations across the country in all eight NQF councils with a response rate of 19% overall. NQF councils represent a broad group of stakeholders including provider organizations, health professionals, quality measurement and improvement experts, consumers, health plans, suppliers and, public/community health agencies and purchasers.

LEVEL OF ACTIVITY ON EACH OF THE SIX PRIORITY AREAS OF THE NQS:

86% Patient safety

82% Effective communication and care coordination

66% Person- and family-centered care

62% Affordable care

60% Prevention and treatment of leading causes of mortality

43% Health and well-being

Overall, responses from the survey indicated that members are actively supporting the NQS although the intensity of engagement and range of results varies by the priority area of focus. Respondents were asked to indicate on a scale from no activity to high activity their organization's level of activity on each of the six priority areas of the NQS: Patient safety had the highest level of activity with 86% of respondents indicating high to moderate activity. Closely following was effective communication and care coordination at 82% in the high to moderate range. Person- and family- centered care was at 66%, affordable care at 62% and, prevention and treatment of leading causes of mortality at approximately 60%. Lastly, health and well-being was just over 43%.

Respondents were asked to indicate on a scale from no results to ongoing sustainable results their organizations level of results reached around the six priority areas of the NQS. Once again patient safety ranked the highest with 55% of respondents indicating ongoing sustainable or established results. Prevention and treatment of leading causes of mortality was at 41%, effective communication and care coordination at 37%, closely followed by affordable care at 31% indicating ongoing sustainable or established results. Person- and family-centered care at 22% and health and well-being at 20%.

The survey also asked members to rank high priority measure gaps that were elucidated from a vast array of NQF endorsement projects and partnership activities including the National Priorities Partnership (NPP) and the Measure Applications Partnership (MAP). Following on this, care transition, shared decision-making/care planning and overuse were ranked the top priorities for addressing measure gaps.

Many survey respondents indicated interest in working with each other around the care coordination and patient- and family-centered care areas of the NQS.

The survey results were shared at the National Quality Forum's (NQF) Annual Conference, held on March 7-8, 2013,and created an opportunity for members and interested stakeholders to further engage about the NQS priority areas and provide illustrative examples of the successes and challenges they face every day. The session was well-received

by over 300 members and key stakeholders. During this time, participants reaffirmed the key findings from the survey, and identified success factors and challenges to implementing the NQS. Overwhelmingly, multi-stakeholder collaboration and alignment were identified as critical strategies for overcoming these barriers.

BARRIERS AND CHALLENGES

In the survey and during the annual conference, members described the barriers they are facing in the field when implementing the NQS, several of which are described below.

- **Collecting and sharing meaningful data across settings and stakeholders as a result of:**
  - » Weak infrastructure supports (e.g., slow adaptation of HIT);
  - » Disjointed exchange of data between providers and settings;
  - » Challenges to timely data, particularly patient-reported outcomes and cost information; and
  - » Lack of measures that are understandable and meaningful to patients and consumers.
- **Meeting the specific needs of local communities, such as:**
  - » Appropriate adaptation of measures to community needs, while recognizing the benefits of standardization (e.g., ability to consistently compare results); and
  - » A sense of ownership as a powerful tool for local adoption of NQS priorities and national initiatives.
- **Addressing competing priorities created by:**
  - » Changes in industry;
  - » Lack of staff time and resources;
  - » Resistance to culture change;
  - » Too many initiatives and insufficient bandwidth; and
  - » Perverse and misaligned incentives that make providing the right kind of care difficult.

STRATEGIES AND TOOLS TO ADVANCE THE NQS

To address these barriers, members shared an array of activities at the local, regional and national levels, where they are taking action from many stakeholder perspectives. The most common theme was around collaboration and coordination at every level of the healthcare system; from bedside to boardroom to national policy, the way forward is through collective action. To that end, one participant at the annual conference commented that "members of NQF, as a group of committed action leaders could start to model cooperation and coordination."

In addition to ensuring multi-stakeholder engagement across multiple settings, some of the additional strategies and tools being used by NQF members to advance the NQS are:

Using the NQS to help guide organization goals ("no one should feel a priority does not apply to their work")

- Engaging patients and their families to improve safety and care coordination (e.g., safety rounds to reduce harm, Patient Family Advisory committee, patients are part of Safe patient team)
- Implementing a clear measurement strategy (e.g., transparency of data; use of registries)
- Integrating current evidence-based guidelines into practice (e.g., wound care)
- Applying payment models that support prevention and population health (e.g., bundled payment)
- Leveraging organizational leadership (e.g., Board level engagement, visible leadership at C-suite level, physician and nurse champions)
- Aligning accountability and external pressures to achieve outcomes
- Capturing data throughout the care process, across and between settings
- Building data collection systems to meet growing demands, to serve as a foundation for quality measures

The NQF's Online Action Registry **(OAR)** continues to serve as a mechanism for ongoing sharing of activities geared towards the advancement of the NQS goals and where the tools and strategies shared at the conference could be shared more widely.

The survey and annual conference provided a unique opportunity to monitor NQS progress through the vantage point of NQF membership. This is part of an ongoing dialogue needed to advance the priorities and goals of the NQS.

Board Update: 2013 Measure Applications Partnership Pre-Rulemaking Enhancements and New Work

During 2013, MAP will strengthen and enhance the annual pre-rulemaking process, while continuing work to identify performance measures for dual eligible beneficiaries and taking on new work to support performance measurement for Health Insurance Exchanges.

Enhancing Pre-Rulemaking Activities

Throughout the 2012/2013 MAP pre-rulemaking cycle, NQF worked with external stakeholders and staff from the Centers for Medicare & Medicaid Services (CMS) to determine ways to enhance the pre-rulemaking process. As a result of this effort, NQF and CMS staff have identified improvements to the list of measures under consideration and better ways to review large volumes of measures. NQF staff will provide MAP members with more detailed information about the Federal programs being reviewed, including information regarding potential measure impact. As a first step toward enhancing MAP's input on the large number of measures used in clinician programs, NQF convened the Clinician Workgroup in April to review measures that are applicable to clinician groups (i.e., Physician Quality Reporting System (PQRS) measures included in the Clinician Group Reporting Option).

Review of Currently Finalized Measure Sets

MAP reviews measures under consideration in the context of their contributions to currently finalized program measure sets. Prior experience has demonstrated that the pre-rulemaking timeline does not allow sufficient time to review currently finalized measure sets for many of the programs before reviewing measures under consideration. To address this concern, NQF is proposing that MAP review currently finalized measure sets for select programs prior to the pre-rulemaking cycle to allow more thoughtful review of the currently finalized measures and make the winter pre-rulemaking meetings more efficient.

Measure Selection Criteria

In 2011, MAP established Measure Selection Criteria (MSC) to guide its input on the selection of measures. The criteria have become an essential tool to support MAP decision making; however, MAP members have recognized the need for enhancement of the criteria. In particular, during the last pre-rulemaking cycle, the Clinician and Hospital Workgroups found it necessary to develop guiding principles for applying measures to specific types of programs. These principles will be integrated into the MSC for subsequent use to avoid competing selection criteria.

Continuation of Dual Eligible Beneficiaries Work

MAP will resume its exploration of the implications of measurement for high-need dual eligible beneficiaries. In particular, MAP will focus measures for individuals with serious mental illness, substance use disorders, intellectual/developmental disabilities, and other types of cognitive

impairment (e.g., dementia). After identifying the best available measures to address high-leverage issues within these subpopulations, MAP will re-examine its evolving core set of measures and the previously identified measures for other high-need beneficiaries (i.e., complex older adults and adults 18-64 with physical disabilities) and establish a single family of measures relevant to the needs of all dual eligible beneficiaries.

Health Insurance Exchanges

The Affordable Care Act (ACA) requires CMS to develop a Quality Rating System (QRS) to be used to gauge the quality of care delivered by qualified health plans (QHPs) offered through the Health Insurance Exchanges (HIEs). MAP is tasked with considering how the hierarchical structure, organization, and measures proposed for the core measure set address the QRS' purpose of informing consumer choice and enabling regulatory oversight of QHPs. MAP will form an HIE QRS Task Force comprising current MAP members with relevant interests and expertise, to advise the Coordinating Committee on this task. Adequate consumer representation and expertise will be particularly important for this task, given that an important purpose of the QRS is to support consumer decision-making regarding plan selection.

NATIONAL QUALITY FORUM

TAB F

To: NQF Board of Directors

From: Ann Greiner

Re: SFQ/NQF Congressional Outreach

Date: May 8, 2013

BOARD DISCUSSION

This memo provides a quick overview of Congressional/Administration outreach efforts since inclusion of the MIPPA extension ($10 million for FY 13) in the fiscal cliff legislation passed on New Year's Day. The bottom line is that we are making progress in improving our standing with House Republicans (who are our most ardent critics), and are in serious discussions with Republican and Democratic Senate offices about introducing a bill with Stand for Quality (SFQ) provisions. This is all positive, but considerable work lies ahead to secure champions/supporters for our bill and to get the provisions included in the most likely vehicle for our proposal, SGR reform legislation likely to be introduced in the summer or later in 2013.

SFQ/NQF PROPOSAL FOR LONG TERM SUPPORT OF QUALITY MEASUREMENT

The first quarter of the year was largely spent on reconnecting with target congressional offices. The purposes of these visits were to:

- Thank them for the inclusion of the MIPPA extension in the fiscal cliff bill, or to let them know that our provision had been included if they were more on the periphery.
- Discuss efforts underway at NQF to streamline the measure endorsement process and to potentially partner with others to facilitate a more coordinated and strategic focus for measure development. See the attached memo distributed to committee staff on both sides of the aisle (Appendix A).
- Get feedback from them about ideas they may have to potentially include in SFQ's 2013 proposal. SFQ's 2012 proposal included support for measure development (funds would go to CMS and these developers, not NQF); level funding for existing NQF duties plus a new duty: feedback loops that provide information on use and usefulness of measures; and support for AHRQ to evaluate usefulness of NQF measures. We anticipate very modest changes around the edges for the 2013 SFQ proposal.

The result of these meetings has been positive feedback from staff about NQF efforts to lean our endorsement process, and identification of potential Senate champions for a bill focused on SFQ provisions, including Senators Klobuchar (D-MN), Bennet (D-C0), and Crapo (R-ID).

In February, we also visited House Republican Physician/Nurse Members in conjunction with specialty society colleagues — American College of Cardiology, the American College of Surgeons, and the Society of Hospital Medicine — to demonstrate support for NQF in the physician community. Finally, we met with Republican leadership and key White House and Administrative leadership. For the latter, we were focused on getting quality measurement included in the President's budget. We were pleased that $100,000 million was included for quality measurement in President Obama's 2014 budget, a strong signal to Capitol Hill about how important the Administration views this work.

NQF TECHNICAL SUPPORT FOR CONGRESSIONAL POLICY EFFORTS

One of the most important policy discussions on Capitol Hill is focused on retiring the SGR formula and putting a reformed physician payment policy in its place. A recent CBO score cut in half the estimate of the cost to retire the SGR, which has added urgency for tackling this issue in 2013. Given that all of the proposals being discussed anticipate a reliance on quality measurement, this policy context has greatly enhanced the relevance of the SFQ legislative proposal. We have worked hard to leverage this interest, and to offer NQF as a technical resource about physician-level measurement to inform the Hill's policy development efforts.

During March and April, we met repeatedly with staff from the key committees of jurisdiction to brief them about: the current state of physician-level performance measurement; what can be expected in the immediate future; and the technical and political challenges in this area. We also spent considerable time explaining how endorsement works; why it matters for high stakes applications such as payment and reporting; and why measures fail to be endorsed.

This latter discussion was particularly relevant as the current Republican House proposal includes consideration of an additional entity or process for measure review and approval. House Democrats (E&C, W&M) and Senate Finance Democrats are not enamored with this idea; Senate Finance Republicans also seem in favor of retaining a single endorsement process, but this could change.

One important outgrowth of this work was an invitation to testify about quality measurement at a 5/7 Bi-partisan Ways and Means hearing on "Developing a Viable Physician Payment Policy." Dr. Frank Opelka, incoming chair of CSAC and Executive Vice President for Health Care and Medical Education Redesign, Louisiana State University, testified on NQF's behalf. See the attached testimony in Appendix B.

The result of these efforts is twofold:

- We have established NQF as a credible, sought-after resource for the Hill as they develop policies that are measurement-based, and in the process we have deepened staff understanding of what we do and why it matters.
- We have strengthened our relationship and heightened our visibility with Congress, particularly with Republican staffers and some members. Our hope is that this will translate into support for the SFQ proposal – or at least neutrality with respect to House Republicans – in the months ahead.

NEXT STEPS

In May, we are focused on updating the SFQ/NQF legislative proposal for 2013 and on pushing to determine if we can get champions on our bill. This may then involve further updating of our legislative proposal, as the champions take ownership.

We are also continuing to work hard at building relationships with specialty societies as they are key to convincing Republican Congressional staff working on physician payment reform about the value of NQF. In June, we are planning a Hill Day with NQF and physician representatives from key specialty societies and the AMA to target physician/nurse House Republican Members.

With respect to timing, the Hill is very focused on reporting out a bill to reform physician payment before the August recess, and this is the most likely vehicle for the SFQ proposal/bill. Many believe that this is a bridge too far given the complexity and cost of physician payment reform, and that this legislation is likely to be delayed until the end of the year. In any event, we will be prepared to take advantage of the opportunities when presented – whether it is wholesale reform or another SGR update at the end of the year. Under the latter scenario, we may have to settle for another one year extension instead of our proposed longer term funding. Time will tell, and to state the obvious, this is not entirely within our hands. That said, we are making good progress.

Accelerating National Quality Strategy Goals by Bringing Critical Quality Measures into the Health Care System More Rapidly

Draft Concepts for Discussion

NQF has informally solicited feedback on ways to more rapidly bring critical quality measures into the health system to accelerate HHS's National Quality Strategy goals. In these conversations, many ideas have emerged to make the measure development and endorsement process more nimble and efficient.

This document lays out ideas NQF is already putting in place;, some which could be addressed by NQF in partnership with others; and some ideas that might be best tackled via legislation.

I. Actions NQF is Taking

Re-engineering and Speeding Up NQF's Measure Review and Endorsement Process

- NQF is moving forward with redesign efforts to reduce the wait for developers to submit measures to NQF and to decrease the time for measure evaluation/endorsement. This plan would build upon the 2012 effort that reduced review cycle time from 12 to 7 months.
- The redesign includes setting up standing committees, implementing a new approach to technical review of measures, and changing NQF's approach to public comment:
  - *Standing Committees*: NQF will move from committees appointed for each project to topical Standing Committees. With training and facilitation resources, standing Committees will provide greater consistency and a more global view of measures in a topical area. Standing committees would reduce project start-up time; reduce time between measure submission and measure review; and move to single flow processing of measures, i.e., review measures one at a time.
  - *Technical Review:* NQF will solicit blinded peer reviews on the technical aspects of the NQF evaluation, including evidence, reliability and validity. These multiple peer reviews should provide consistent and unbiased input to the Standing Committees.
  - *Open Comment*: NQF will move to a more continuous, open commenting model on all measures, newly submitted and endorsed. This will enhance the information from the field on measures under consideration and provide NQF member and public input prior to committee recommendations.

II. Ideas NQF Can Advance with Partners

Use an Existing Forum to Partner with Stakeholders to Increase Collaboration and Appropriately Expedite the Development and Testing of Critical Quality Measures

- NQF has heard from some partners in the quality measurement community about the lack of communication across stakeholders involved in measure prioritization, development, and testing. NQF has also heard concerns about the time and effort required to develop, test and submit measures to NQF.
- To address these challenges, NQF is discussing plans with partners in the quality community to facilitate a forum that provides
    - A streamlined way to openly exchange information about the status of measures under development;
    - Collaborative "matchmaking" between developers and funders;
    - Linkages between those who have innovative measures and developers;
    - An early opportunity for multi-stakeholder input into measure development;
    - Facilitation of linkages to test beds and EHR vendors.
- The result could be virtual collaboration among measure developers, funders and other stakeholders prior to investing substantially in measure development projects and before submitting measures to NQF for endorsement.
- An effort such as this could help reduce redundancy in measure development; allow measure developers to share learnings and best practices; give measure developers a chance to harmonize/collaborate on similar measures; and accelerate measure testing.
- To be clear, NQF does not develop measures under this or any other scenario and would put in place firewalls to protect the integrity of the review process.

Seek Multi-Stakeholder Input into Prioritizing the Filling of "Measure Gaps"

- In current statute, NQF is required to "identify" critical quality measurement gaps relative to achieving the HHS National Quality Strategy.
- However, there is no existing mechanism for bringing stakeholders together to determine which of these gaps are the "highest priority" to address.
- In response, the Measure Applications Partnership recommended in its 2012 strategic plan that an NQF-convened group establish a transparent and inclusive process for prioritizing measure gaps in order to catalyze development of high priority measures.
- NQF proposed to CMS (3/13) that the National Priorities Partners prioritize measure gaps to fill.

III. Ideas Proposed for Legislation

Increase Efforts to Better Align Public and Private Sector Use of Measures

- NQF has heard from policymakers and stakeholders about the critical need to reduce administrative burden and increase impact of quality measurement by better aligning, or using the same measures, across programs.

- Today, the NQF convened Measure Applications Partnership (MAP) provides input to HHS on ways to improve alignment across public programs.
- Although alignment between public and private sector programs is an expected byproduct of MAP recommendations, alignment is not explicitly called out in existing statute as a purpose of MAP, and some believe alignment should be made explicit.

Establish Better Mechanisms to Understand the Use and Usefulness of Measures (Included in the SFQ 2012 Proposed Legislation)

- NQF continues to hear concerns that a part of the "quality story" is missing; namely, feedback about the use and usefulness of measures. Today, while the health community focuses on ramping up quality measure development, improving the endorsement process, and reviewing the suitability of measures for specific uses, there is a dearth of information about the implementation of quality and efficiency measures.
- NQF could put a process in place to enable systematic collection, analysis, and annual reporting of relevant information on measure implementation
- The feedback information could then be used to inform the range of stakeholders who participate in the NQF endorsement, selection, and review processes, as well as policymakers and others using measures to improve care on the frontlines.

IV. Summary

These ideas could streamline and speed up the measure development, endorsement and implementation feedback processes by:

- ✓ Facilitating multi-stakeholder input into setting priorities with respect to the filling of identified measurement gaps;
- ✓ Accelerating the development of measures against this set of priorities through an existing forum that would foster communication, collaboration and a more efficient development process;
- ✓ Speeding up NQF endorsement and decreasing the wait time to get into the measure review process;
- ✓ Fostering better alignment between the public and private sectors on use of the same quality and efficiency measures to reduce wasteful redundancy and accelerate improvement; and
- ✓ Increasing understanding of which measures are being used and which are useful for driving improvements in performance.

NATIONAL QUALITY FORUM

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"Developing a Viable Physician Payment Policy"

Statement of:

Frank G. Opelka, MD, FACS
Vice Chair, Consensus Standards Approval Committee
Measure Applications Partnership
National Quality Forum

Executive Vice President for Health Care and Medical Education Redesign, Louisiana State University

Prepared for the Committee on Ways and Means
Subcommittee on Health

May 7, 2013

Written Testimony for House Ways & Means

Health Subcommittee Hearing

May 7, 2013

Thank you Chairman Brady and Ranking Minority Member McDermott for inviting me to participate in today's hearing and provide testimony on behalf of NQF.

My name is Dr. Frank Opelka. I am a member of the NQF-convened Measure Applications Partnership and the Vice Chair of NQF's Consensus Standards Approval Committee (CSAC); I will become Chair of CSAC in July. CSAC oversees measure evaluation and endorsement at NQF. I am a surgeon and in my day job, the Executive Vice President for Health Care and Medical Education Redesign at Louisiana State University as well as the Associate Medical Director for the American College of Surgeons.

Background on NQF

Founded in 1999, NQF is a non-profit, non-partisan organization with over 440 organizational members. NQF members span the health care spectrum, including physicians, hospitals, businesses, consumer and patient representatives, health plans, certifying bodies and other healthcare stakeholders.

NQF has two distinct but complementary roles focused on enhancing the quality and value of the U.S. health care system:

- **NQF reviews and endorses quality performance measures.** These measures are used by public and private payers to assess how well doctors, hospitals and other providers are doing in offering high-quality care, and are also used by providers to benchmark their performance against peers and national standards. About two-thirds of the measures that the federal government uses in its healthcare programs are NQF endorsed. There is also widespread use of NQF-endorsed measures by hospitals and health plans at the state, regional and local levels.
- **In addition to endorsing measures, NQF also convenes diverse, private sector healthcare stakeholders to provide input to the Department of Health and Human Services (HHS) quality improvement efforts.** More specifically, the NQF-convened National Priorities Partnership (NPP) has served as a forum for a diverse group of stakeholders to provide initial and ongoing input to the HHS developed National Quality Strategy (NQS), which is focused on improving care, increasing affordability and building healthier communities. The NQF-convened Measures Application Partnership (MAP) is another diverse stakeholder group that works together to make recommendations on which measures should be used in Federal payment and

public reporting programs, including Hospital Value Based Purchasing and the Physician Quality Reporting System (PQRS), among others.

NQF's Board of Directors is composed of 31 voting members—key public- and private-sector leaders who represent major stakeholders in America's healthcare system (see Appendix A). A distinguishing characteristic of NQF is that our by-laws stipulate that a majority of the Board must be representatives of patients/consumers and purchasers, which assures a strong voice for those who receive care and those who pay for care. By practice, patient representatives are prominent in all NQF committees and workgroups.

NQF is recognized as a voluntary consensus standard-setting organization under the National Technology Transfer and Advancement Act of 1995. Its process for reaching consensus adheres to the Office of Management and Budget's formal definition of consensus.[i] NQF is supported by membership dues, foundation grants, and Federal funding.

Why We Are Here Today

Mr. Chairman, we commend you and your entire committee for undertaking the critical task of reforming physician payment and for placing health care quality at the center of your efforts. Concentrating on health care quality is the right medicine for making our system more patient-focused, along with improving outcomes and reducing costs.

It may sound simple but it is true that focusing on quality will only work if the tools we use to measure are themselves "high quality". For quality measurement to have an impact, the measures must be rigorous and held to high medical and scientific standards. Also, it is critical that a range of stakeholders be involved in choosing which measures will drive the biggest improvements.

At Louisiana State University, I see the power of using standardized measures to compare and contrast different hospitals and provider groups within our system, and to gauge our institution's performance against other hospital systems both regionally and nationally. This kind of feedback and transparency motivates improvement.

It is why I and over 400 other physicians take time away from our practices to serve on NQF committees. Along with experts from other stakeholder groups – totaling about 850 volunteers strong in 2012 and logging about 55,000 hours, translating into approximately a $4 million contribution – we collectively embody NQF's public service mission to improve the health of the nation.

Why High Quality Measures Matter

Mr. Chairman, all of the "measures" work my professional colleagues do is predicated on a precious few goals – to improve care, get optimal use of affordable resources, and to engage patients and make care more patient centered.

There is no one size fits all for measures, rather there are different types of measures for different purposes. There are many measures that physicians use that help them improve the way they practice such as many measures contained in registries or maintenance of certification programs, but which are not necessarily appropriate for public reporting or payment purposes.

NQF's current focus is on measures that are linked to high stakes reporting or payment, which need to be standardized and vetted through a rigorous multi-stakeholder process. Examples of these measures and the difference they make include:

- **NQF-endorsed measures on infections are driving care improvements:** Many have contributed to patient safety gains in hospitals, including a CDC-reported 58 percent reduction in central line associated blood stream infections (CLABSIs) between 2001 and 2009, which is the window of when a new NQF measure in this area came into use. This represents up to 6,000 lives saved and approximately $1.8 billion saved in cumulative excess health-care costs.ii
- **Publicly reported NQF-endorsed measures improved physician group performance:** Physician groups in Wisconsin that publicly reported quality measures between 2004-2009 improved their performance on key indicators, e.g., cholesterol control and breast cancer screening, outperforming peers in the rest of Wisconsin, nearby states of Iowa and South Dakota, and the U.S. as a whole. [iii]
- **Hospitals that use NQF-endorsed measures have better outcomes:** A peer reviewed study of more than 650 hospitals showed a decline in mortality in those hospitals that have fully implemented NQF endorsed Safe Practices.iv
- **NQF's focus on endorsing measures related to prenatal care is making a difference:** The Joint Commission requires hospitals to report on elective delivery prior to 39 weeks. A recent study found that the rate of neonatal intensive care unit (NICU) admissions dropped by 16 percent in 27 hospitals focused on reducing elective deliveries – and that if widely implemented across the country this could result in a dramatic drop off of admissions and hundreds of millions of savings per year.v

Measure Development and Endorsement

Let me now talk about where measures come from and where NQF fits in.

Measures are brought to NQF by over 65 different developers including physician specialty societies, the American Medical Association, The National Committee for Quality Assurance (NCQA), academic and community organizations and others. More than half of NQF's chairs of committees are physicians, and about 30 percent of all measures in NQF's portfolio are developed by medical specialty societies. These measures are largely derived from clinical guidelines. As part of the measure development process, NQF requires developers to test the measures and submit the test results that demonstrate their measures are valid and reliable. NQF does not itself develop measures; we think that would be a conflict of interest. Rather, our job is to assure that measures meet rigorous standards. Let me explain how.

NQF assembles committees with the right specialty expertise on the topic at hand, whether that is related to appropriateness for cardiac imaging or best surgical care. Forty-eight percent of the experts on these committees are physicians who bring their deep clinical expertise to the table; the other half represent patients, payers, hospitals, and others with a stake in healthcare. Overall, these diverse perspectives are helping to move measures from being provider centric to be more patient centered and are reflective of where we collectively want to drive the healthcare system.

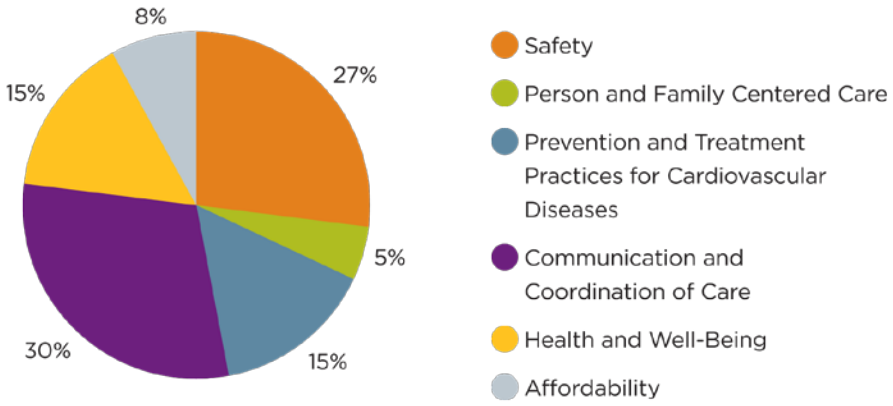
When these multi-stakeholder committees are convened, their task is to evaluate sets of measures against agreed upon standards. About 70 percent of measures reviewed are endorsed and receive the NQF good housekeeping seal of approval. In order to receive NQF endorsement, measures must meet key endorsement criteria:

- **Importance to measure and report** – This criteria evaluates whether the measure has potential to drive improvements, including care improvements, and includes a careful evaluation of the clinical evidence
- **Scientific acceptability of measure properties** –This criteria evaluates whether the measure will generate valid conclusions about quality; if measures are not reliable (consistent) and valid (correct), they may be improperly interpreted
- **Usability and use**– This criteria evaluates whether the measure can be appropriately used in accountability and improvement efforts
- **Feasibility** – This criteria requires evaluators to review the administrative burden involved with collecting information on the measure. If a measure is deemed too burdensome, alternative approaches need to be considered
- **Assess related and competing measures** – This criteria requires evaluators to determine whether the measure is duplicative of other measures in the field. NQF endorses best-in-class measures and where appropriate combines (harmonizes) similar measures to reduce burden associated with requests to report near-identical measures.

NQF strategically manages its portfolio of about 700 endorsed measures to simultaneously increase impact and decrease burden on providers, growing the measure portfolio in some

areas and shrinking it in others. NQF replaces existing measures with those that are better, reflect new medical evidence, or are more relevant; removes measures that are no longer effective or evidence-based; and expands the portfolio to bring in measures necessary to achieve the National Quality Strategy.

How NQF-Endorsed Measures Stack-Up Against National Quality Strategy Priorities



NQF plays an important role in the harmonization and alignment of performance measures. In the surgical world, NQF served as a key facilitator of a harmonization process between the American College of Surgeons and the CDC to achieve a single national standard for surgical site infections. For something as important as infections after surgery, there needs to be one and only one national standard to drive improvement. NQF has also worked to ensure that measures are aligned across populations and payers. NQF pressed CMS to expand key outcome measures like 30-day mortality beyond the Medicare population so that providers can be judged on their whole patient population. To move performance measurement into the future, NQF can play a critical role in ensuring that the building blocks of measures, like data elements and value sets used to define diabetes or heart failure, are harmonized, reliable and valid.

Rigorous standards are imperative to physician and purchaser confidence in and use of measures. The Committee is right to link rigorous measures to payments, just as you would be right to reject using poor quality measures that will fail to drive the system to be more patient centered and higher performing. Pursuit of the latter will add to cost and burden with no improvement in care.

Retaining a Single Measure Review and Endorsement Process

As policymakers consider payment reforms that focus on quality performance, I strongly believe that ensuring there is one central hub of measure review and endorsement – such

as has been created at NQF – allows for the most efficient, rapid, inclusive and effective process for bringing new quality measures into the system.

I know that there are proposals under consideration that would set up an additional process for approving measures. NQF and its wide range of stakeholders – including businesses, consumer groups, health professionals and plans -- are concerned that establishing a separate process will simply result in more cost and redundancy and will do little to move the ball forward in bringing effective, consensus-based quality measures into the health system.

Having an additional process for measure review would likely result in more "look alike" measures and lack of alignment in use of the same measures – both would add to data collection and reporting burden. And when the measure results were publicly reported, it would lead to confusion about whether they were comparable. Having said that, and to be absolutely clear, we welcome and are committed to finding ways to enhance and evolve the measure development, endorsement, and selection process and commend you for opening up the conversation on the critically important issue of getting better measures to market more rapidly.

Our stakeholders also believe it's important that they have a constructive seat at the table. Having HHS review and approve submitted measures instead of the existing consensus-based entity would mean that private sector stakeholders may have less opportunity for ongoing input into the measure review and approval process. Ensuring all stakeholders have a substantive role in this process ensures that the highest quality measures are approved that can drive real change in moving toward a lower cost, patient-centric healthcare system.

Additional Background on NQF's Portfolio of Endorsed Measures: 2012 at a Glance

By way of further background on the role NQF has played in bringing quality metrics to market, let me provide further details on NQF's recent work.

In 2012, NQF completed 16 endorsement projects -- reviewing 430 submitted measures and endorsing 301 measures, or 70 percent. This included 81 new measures and 220 measures that maintained their endorsement after being considered in light of any new evidence and/or against new competing measures submitted to NQF for consideration.

More specifically in 2012, NQF endorsed:

- **Patient safety measures.** Americans are exposed to more preventable medical errors than patients in other industrialized nations, costing the United States close to $29

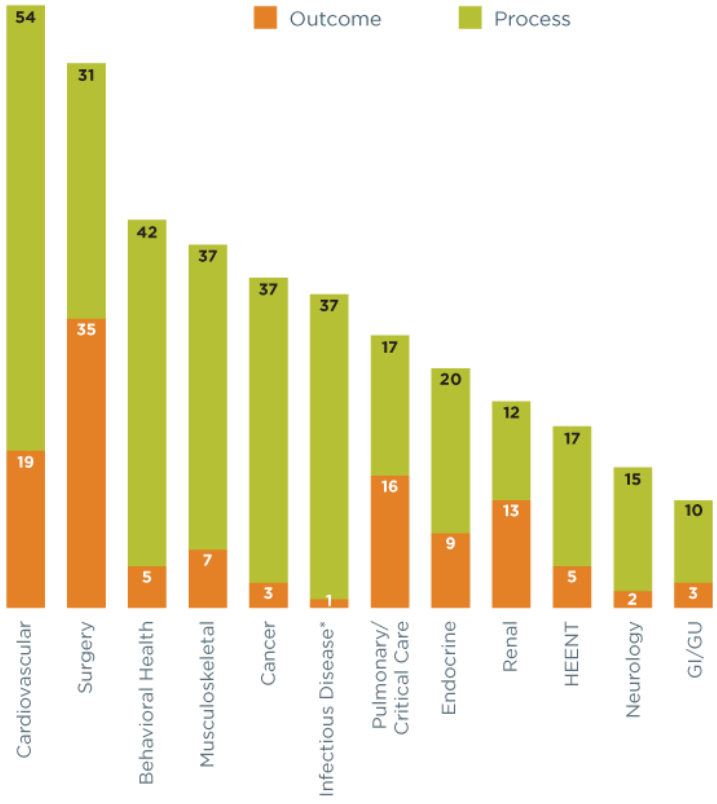
billion per year in additional healthcare expenses, lost worker productivity, and disability.[vi] NQF endorsed 32 patient safety measures in 2012, focusing on complications such as healthcare-associated infections, falls, medication safety, and pressure ulcers. ,

- **Resource use measures.** The full spectrum of healthcare stakeholders is increasingly attuned to affordability and focused on how we can measure and reduce healthcare expenditures without harming patients and improving care. NQF endorsed its first set of resource use measures—designed to understand how healthcare resources are being used—in January 2012, and it endorsed an additional set in April 2012. These measures are primed to offer a more complete picture of what drives healthcare costs. Used in concert with quality measures, they will enable stakeholders to identify opportunities for creating a higher-value healthcare system.
- **Patient experience measures.** Measures endorsed include a measure evaluating patient satisfaction during hospitalization for surgical procedures; measures focused on effective provider communication with patients regarding disease management, medication adherence, and test results; seven related measures that address health literacy, availability of language services, and patient engagement with providers; and measures that evaluate how bereaved family members perceive care provided to loved ones in long term care facilities and hospitals.
- **Harmonized behavioral health measures.** In 2012, NQF endorsed 10 measures related to mental health and substance abuse, including measures of treatment for individuals experiencing alcohol or drug dependent episodes; diabetes and cardiovascular health screening for people with schizophrenia or bipolar disorder; and post-care follow-up rates for hospitalized individuals with mental illness. As a part of this process, NQF also brought together CMS and the National Committee for Quality Assurance (NCQA) to integrate two related measures into one measure, addressing antipsychotic medication adherence in patients with schizophrenia.
- **A measurement framework for those with multiple chronic conditions.** People with multiple chronic conditions (MCCs) now comprise more than 25 percent of the U.S. population[vii,viii] and are more likely to receive care that is fragmented, incomplete, inefficient, and ineffective.[ix,x,xi,xii,xiii] Yet despite the growing prevalence of people with MCCs, existing quality measures typically do not address issues associated with their care, largely because of data-sharing challenges and because measures are typically limited to addressing a singular disease and/or specific setting. As a response to these challenges, NQF endorsed a measurement framework that establishes a shared vision for effectively measuring the quality of care for individuals with MCCs that developers can use to more expeditiously create measures for this population.
- **Healthcare disparities measures.** Research from the Institute of Medicine shows that racial and ethnic minorities often receive lower quality care than their white counterparts, even after controlling for insurance coverage, socioeconomic status, and comorbidities.[xiv] NQF commissioned a paper outlining methodological issues and an approach to identify measures that are more sensitive to disparities and as such should be stratified. From there, NQF endorsed 12 performance measures, focused on patient-provider communication, cultural competence, language services, and others.

In addition to the endorsement activities highlighted above, NQF is consistently working to ensure resources are devoted to the highest priority work. These initiatives include:

- ***Periodic review of measures to ensure NQF-endorsed measures are up-to-date:*** The size of NQF's portfolio declined in 2012 through retiring competing measures, or removing measures where performance was already topped out at very high levels. Specifically, 93 new measures were added and 103 were removed from the NQF portfolio.
- ***An ever-increasing focus on endorsing outcome measures, which have the greatest promise for improving care and reducing costs:*** At the end of 2012, 27 percent of the measures in NQF's overall portfolio were outcome measures, compared to 24 and 18 percent in 2011 and 2010, respectively. See the chart below for more specificity about NQF-endorsed condition-specific measures, which provide some insight as to the degree a given physician specialty is likely to have outcome measures. Overall the proportion of outcome measures differs across conditions, with proportionally higher percentages of outcome measures for surgery and cardiac care.

Measures Receiving NQF Endorsement in 2012, by Category



*Additional outcome measures captured in safety areas (not shown).

Why Measures Fail Endorsement

While roughly 70 percent of measures submitted to NQF in 2012 received endorsement, other measures did not because they did not adequately meet NQF's rigorous scientific, clinical and other criteria detailed above.

Of the measures that were not endorsed by NQF last year, the vast majority failed to meet the "importance to measure" requirement. The criterion of importance to measure and report is intended to ensure that performance measurement and reporting are focused in areas that have the greatest leverage for driving improvements in quality of healthcare and patient outcomes.

Many things that *can* be measured require additional actions before they can have any meaningful effect for patients. For example, ordering a lab test will not improve care and outcomes unless the results are reviewed in a timely manner, interpreted correctly, and followed with the appropriate treatment. For most measures that failed the importance criterion, there was limited evidence to suggest that a measured "process" had any relation to desired outcomes. Some measures had very high levels of performance with limited opportunity for further improvement. Other measures, especially at the hospital level, did not have fulsome enough risk adjustment to adequately distinguish between quality and unmeasured patient risk (e.g., severity of illness).

Illustrative examples of measures that failed to pass endorsement follow:

- ***No evidence of relation between a measured process and desired patient outcomes***: An NQF expert committee failed to recommend a measure regarding seizures because the measure focused simply on whether the "type of seizure" was documented, rather than how this documentation could be used by clinicians to determine the appropriate care and/or improve outcomes.
- ***Process measure too distal from effect on outcomes***: A measure of whether a physician considered using thrombolytic therapy was rejected in favor of a measure of actually administering life-saving thrombolysis to patients. A measure that included only whether a pain assessment was completed, without assessing whether an intervention reduced pain failed importance.
- ***Lack of a performance gap in care***: Measures that focus on areas where performance is already high are frequently rejected in favor of measures that focus on areas where there are clear deficits in performance. For example, the compliance rate for assessing neonates' initial temperature in the NICU is already at 98 percent. Given this, a recent measure in this area was rejected because the

expert committee determined that such a measure did not meet the "importance" threshold.

- ***Lack of adequate risk adjustment****:* For outcome measures, it is critically important that the measures be risk adjusted to ensure that measurement reflects true outcomes of care, rather than unmeasured severity of illness. In the last year, NQF rejected measures related to stroke mortality and readmissions due to concerns related to adequate risk adjustment. A composite measure of adverse perinatal events was also not approved due to the absence of risk adjustment.

For measures that do not meet rigorous standards, there is an inherent risk in using them. The variation reported may not be true differences in quality across providers but rather measurement "noise." Further, linking payment to poor quality measures will not drive the system to be more patient centered or higher performing and instead will add cost and burden. Linking payment to poor quality measures is not a responsible expenditure of Federal dollars.

Evolving Endorsement as the Science of Measurement Changes

As the healthcare system continues to evolve and demand greater focus on healthcare quality and improvement, I thought I should also spend a minute providing information on how NQF is evolving its processes to meet increasing demand for endorsed measures. For example, over the last year, NQF has solicited feedback on ways to more rapidly bring critical quality measures into the health system. As part of this effort, the organization is moving forward with redesign efforts to reduce the wait for developers to submit measures to NQF and to decrease the amount of time it takes for measures to get through the NQF review process. This plan builds upon the success NQF has already had in reducing the measure review cycle time from 12 to 7 months.

- To provide a few more specifics, some of NQF's re-design efforts include setting up standing committees to expedite the review process, implementing a new approach for technical review of measures, and changing NQF's process for public comment:
  - ***Standing Committees***: NQF will move to Standing Committees, away from committees appointed for each project that receive submissions after a Call for Measures. Standing committees would reduce project start-up time; reduce time between measure submission and measure review; and move to single flow processing of measures, i.e., review measures one at a time. With training and facilitation, standing Committees also will provide greater consistency and a more global view of measures in a topical area.
  - ***Technical Review****:* As a way to provide more consistency and objective input to the Standing Committees, NQF will incorporate peer reviews on the technical aspects of the NQF evaluation, including evidence, reliability and validity. These multiple peer reviews should provide consistent and unbiased input to the Standing Committees.

- ***Open Comment***: NQF will move to a more continuous, open commenting model on all measures, newly submitted and endorsed. This will enhance the information from the field on measures under consideration and provide NQF member and public input prior to committee recommendations.

All of these efforts are helping ensure NQF is ready and capable to meet the growing demand for quality improvement and quality measurement as our healthcare system continues to evolve.

Thank you for this opportunity to provide the Ways and Means Health Subcommittee testimony on behalf of the National Quality Forum. I am happy to answer your questions or elaborate further on any points made in my testimony.

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[i] The White House, U.S. Office of Management and Budget (OMB). *Circular No. A-119*, February 10, 1998. Washington, DC: OMB; 1998. Available at www.whitehouse.gov/omb/circulars_a119/. Last accessed January 2012.

[ii] Vital Signs: Central Line Associated Blood Stream Infections, MMWR http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6008a4.htm

[iii] Lamb, GC, Smith, MA, Weeks, WB, Queram, C. Publicly Reported Quality-Of-Care Measures Influenced Wisconsin Physician Groups To Improve Performance. Health Aff March 2013 32:536-543;

[iv] Brook SB, Dominici F, Pronovost PJ, et al. Variations in surgical outcomes associated with hospital compliance with safety practices. *Surgery*. 2012; 151(5):651-659.

[v] Clark, Steven L., MD, Donna R. Frye, RN, MN, Janet A. Myers, RN, Michael A. Belfort, MD, PhD, Gary A. Dildy, MD, Shalece Kofford, RN, MPH, Jane Englebright, RN, PhD, and Jonathan A. Perlin, MD, PhD. "Reduction in Elective Delivery at." *American Journal of Obstetrics and Gynecology*, November 2010.

[vi] Institute of Medicine. *To Err is Human*. Washington, DC: National Academies Press; 2001.

[vii] Department of Health and Human Services (HHS), Office of the Assistant Secretary for Health (ASH), *Initiatives*, Washington, DC: HHS, ASH: 2011. Available at http://www.hhs.gov/ophs/initiatives/mcc/index.html. Last accessed December 2011.Available at http://www.hhs.gov/ophs/initiatives/mcc/index.html. Last accessed December 2011.

[viii] Thorpe KE, Howard DH, The rise in spending among Medicare beneficiaries: the role of chronic disease prevalence and changes in treatment intensity, *Health Aff*, 2006;25(5):w378-w388.

[ix] Gijsen R, Hoeymans N, Schellevis FG, et al., Causes and consequences of comorbidity: a review, *J Clin Epidemiol*, 2001;54(7):661-674.

[x] Boult C, Wieland GD, Comprehensive primary care for older patients with multiple chronic conditions: "nobody rushes you through", *JAMA*, 2010;304(17):1936-1943.

[xi] Parekh AK, Barton MB, The challenge of multiple comorbidity for the US health care system, *JAMA*, 2010;303(13):1303-1304.

[xii] Wolff JL, Starfield B, Anderson G, Prevalence, expenditures, and complications of multiple chronic conditions in the elderly, *Arch Intern Med*, 2002;162(20):2269-2276.

[xiii] Boyd CM, Boult C, Shadmi E, et al., Guided care for multimorbid older adults, *Gerontologist*, 2007;47(5):697-704.

[xiv] Institute of Medicine (IOM). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003. Available at http://www.nap.edu/openbook. php?isbn=030908265X. Last accessed August 2012.

Appendix A - National Quality Forum Board of Directors

William L. Roper, MD, MPH, *Chair* Dean, School of Medicine Vice Chancellor for Medical Affairs and Chief Executive Officer, UNC Health Care System, University of North Carolina at Chapel Hill	**Helen Darling, MA, *Vice Chair*** President, National Business Group on Health
Christine K. Cassel, MD Incoming President and CEO	**Gerald M. Shea, *Treasurer and Interim CEO*** Assistant to the President for External Affairs, AFL-CIO
Lawrence M. Becker Director, HR Strategic Partnerships Xerox Corporation	**JudyAnn Bigby, MD** Secretary, Executive Office of Health and Human Services Commonwealth of Massachusetts
Leonardo Cuello Staff Attorney National Health Law Program	**Jack Cochran, MD, FACS** Executive Director The Permanente Federation
Maureen Corry Executive Director Childbirth Connection	**Joyce Dubow** Senior Health Care Reform Director AARP Office of the Executive Vice-President for Policy and Strategy
Robert Galvin, MD, MBA Chief Executive Officer, Equity Healthcare The Blackstone Group	**Ardis D. Hoven, MD** Chair, Board of Trustees American Medical Association
Charles N. Kahn, III, MPH President Federation of American Hospitals	**Donald Kemper** Chairman and CEO Healthwise, Inc.
William Kramer Executive Director for National Health Policy Pacific Business Group on Health	**Harold D. Miller** President and CEO Network for Regional Healthcare Improvement
Elizabeth Mitchell CEO, Maine Health Management Coalition	**Dolores L. Mitchell** Executive Director Commonwealth of Massachusetts Group Insurance Commission
Mary D. Naylor, PhD, RN, FAAN Director, New Courtland Center for Transitions & Health and Marian S. Ware Professor in Gerontology University of Pennsylvania School of Nursing	**Debra L. Ness** President National Partnership for Women & Families

Samuel R. Nussbaum, MD Executive VP and Chief Medical Officer WellPoint, Inc.	**J. Marc Overhage, MD, PhD** Chief Medical Informatics Officer Siemens Medical Solutions, Inc.
John C. Rother, JD President and CEO National Coalition on Health Care	**Bernard M. Rosof, MD** Chair, Board of Directors Huntington Hospital, and Chair, Physician Consortium for Performance Improvement (PCPI)
Bruce Siegel, MD, MPH President and Chief Executive Officer National Association of Public Hospitals and Health Systems (NAPH)	**John Tooker, MD, MBA, FACP** Associate Executive Vice President American College of Physicians
Richard J. Umbdenstock, FACHE President and CEO American Hospital Association	
DHHS REPRESENTATIVES	
CMS Centers for Medicare & Medicaid Services **Designee: Patrick Conway, MD** Chief Medical Officer	**AHRQ** **Carolyn M. Clancy, MD** Director, AHRQ **Designee: Nancy Wilson, MD, MPH** Senior Advisor to the Director
HRSA **Mary Wakefield, PhD, RN** Administrator, Health Resources and Services Administration **Designee: Terry Adirim, MD** Director, Office of Special Health Affairs	**CDC** **Thomas R. Frieden, MD, MPH** Director, Centers for Disease Control and Prevention **Designee: Peter A. Briss, MD, MPH** Captain, U.S. Public Health Service Medical Director
EX OFFICIO (NON-VOTING)	
Ann Monroe Chair, Consensus Standards Approval Committee President, Health Foundation for Western and Central New York	**Paul C. Tang, MD, MS** Chair, Health Information Technology Advisory Committee Vice President and Chief Medical Information Officer Palo Alto Medical Foundation

Meeting of the Board of Directors
November 29, 2012

A meeting of the Board of Directors of the National Quality Forum (NQF) was held on November 29, 2012, at the offices of the National Quality Forum, Washington, DC.

Participants

Board Members: William Roper (Chair); Helen Darling (Vice Chair) (by phone); Gerald Shea (Interim CEO); Terry Adirim; Lawrence Becker; JudyAnn Bigby; Peter Briss; Carolyn Clancy; Maureen Corry; Leonardo Cuello; Joyce Dubow; Robert Galvin; Kate Goodrich (for Patrick Conway, CMS); Ardis Dee Hoven; Charles Kahn, III; Donald Kemper; William Kramer; Harold Miller; Dolores Mitchell; Elizabeth Mitchell; Debra Ness; Samuel Nussbaum; Marc Overhage; Bernard Rosof; Bruce Siegel; Richard Umbdenstock; Nancy Wilson

Non-Voting Ex Officio Board Members: Ann Monroe, CSAC Chair; Paul Tang, HITAC Chair

Staff: Heidi Bossley; Helen Burstin; Ann Greiner; Ann Hammersmith (Corporation Secretary); Nicole Silverman; Jeffrey Tomitz; Thomas Valuck; Wendy Vernon

OPEN SESSION

William Roper, Chair, called the meeting to order in open session at 10:43 a.m.

ACTION: The Board approved the minutes from the September 20, 2012, meeting.

Dr. Roper reported the following from the **executive and closed sessions**, which were held between 8:30 and 10:30:

The Board discussed the CEO search and interim leadership. Gerald Shea and Helen Darling presented an assessment of NQF's progress in meeting its 2012 objectives and reported the Compensation Committee's recommendations. Gerald Shea, Treasurer, and Jeffrey Tomitz, Chief Financial Officer, presented the report of the Finance and Audit Committee, including the proposed 2013 budget.

ACTION: The Board approved the recommendations in the Compensation Committee's Report.

ACTION: The Board approved NQF's 2013 budget.

Minutes of the NQF Board of Directors Meeting
November 29, 2012

2013 Priorities for Federal Agencies

Gerry Shea, Interim CEO, invited federal government representatives to make presentations regarding 2013 priorities for their respective agencies.

Dr. Nancy Wilson presented AHRQ's 2013 measurement priorities and noted that she would focus on things that AHRQ is leading, especially where AHRQ is working with NQF. Dr. Wilson divided her presentation into measurement and improvement priorities.

AHRQ's measurement priorities include:

1. Facilitating measure management across HHS, including work through the Measures Policy Council, which Dr. Wilson and Dr. Kate Goodrich will lead, with the goal of moving beyond alignment and into a process for managing measures from development and implementation through impact;
2. Strengthening and expanding AHRQ quality indicators and converting them to ICD-10;
3. Facilitating state and local public reporting through the use of MONAHRQ (working with NQF) and other tools such as an action toolkit
4. Awarding grants to advance the science of public reporting (NQF is working on two of these grants: MONAHRQ and Children's Hospital in DC);
5. Expanding common formats (working with NQF); and
6. Supporting the use of CAHPS surveys.

AHRQ's improvement priorities include:

1. Focusing on the National Quality Strategy (NQS);
2. Expanding community and state stakeholder outreach;
3. Identifying paths for community capacity to improve health and healthcare;
4. Highlighting innovative initiatives that achieve demonstrable improvement on the NQS goals;
5. Expanding synergies across HHS and other Federal partners, including public reporting; and
6. Preparing the healthcare work force for quality improvement and achieving NQF's goals.

Dr. Peter Briss presented the CDC's 2013 priorities. He identified the CDC's highest value targets as measure application and prioritization. Specifically, the CDC will focus on:

1. Talking collaboratively with measure developers about updating measures and rapidly deploying them for new cardiovascular prevention guidelines on hypertension, cholesterol, and lifestyle;

2. Approving the upcoming JNC Hospital tobacco treatment measures in a rapid timeframe; and
3. Aligning tobacco treatment guidelines with Public Health Service guidelines.

Dr. Kate Goodrich discussed what CMS would like NQF to pay particular attention to in 2013. Those areas include:

1. Focusing measure development efforts on the gap areas identified by NQF and others and mapping those areas to the six domains/priorities of the NQS;
2. Rethinking the measure development process, including the entire measure cycle from concept to endorsement;
3. Improving the two-step Consensus Development Process (CDP) that was piloted:
4. Evolving the process for endorsement of eMeasures specifically;
5. Expanding some measures across multiple settings;
6. Continuing to shorten timeframes for endorsing measures, as well as considering what measure endorsement should mean;
7. Continuing to improve the process for pre-rulemaking input;
8. Continuing MAP's identification of families of measures, as well as reviewing federal measures that don't go through the rulemaking process; and
9. Convening an expert panel to discuss value set harmonization, especially for some of the most common conditions.

Dr. Terry Adirim discussed HRSA's two main measurement priorities in 2013 in light of HRSA funding the healthcare safety net. Those measurement priorities are:

1. Focusing on measures related to the healthcare workforce as these workers have a direct impact on quality of care in healthcare institutions; and
2. Coordinating care in the primary care setting.

Discussion of 2013 Plans

Gerry Shea invited internal strategic planning teams to present their ideas to the Board. Mr. Shea stated that he wanted to (1) allow the Board to see staff they don't normally interact with, and (2) clarify that the planning was done based on projects, not departments. NQF staff would suggest four projects dealing with important issues where NQF believes it can have an impact. Three of these topics relate to NQF's core work of measure endorsement, selection, and recommendation and the fourth project relates to healthcare affordability and value.

Dr. Helen Burstin, Senior Vice President, Performance Measures, added that NQF wants to move toward higher impact measures and a more collaborative role with developers. Important considerations include reducing measure burden and accelerating of work around the eMeasures Collaborative to help with transition to an electronic platform.

Dr. Burstin introduced the measures and burden team. This team recommended:

1. Continuing work on harmonization and working on decision logic with developers;
2. Creating a repository of measure information;
3. Working with developers toward plain English language titles and descriptions for measures; and
4. Creating metrics that allow NQF to not only indicate where measure gaps are being filled but where duplication is being reduced.

Heidi Bossley, Vice President, Performance Measures, introduced the team that worked on creating a path to parsimonious sets of high impact measures. This team recommended more collaboration with measure developers to encourage high leverage measures that add value. The team identified the following ways for NQF to achieve this:

1. Prioritizing measure gaps, usefulness and opportunities to align measures and convening developers to get to the gaps;
2. Creating a virtual measure incubator as a place where people can share as they develop measures;
3. Driving harmonization and alignment;
4. Conducting a national communication and education campaign for developers;
5. Awarding innovative measure development; and
6. Creating a logo that developers and others could use if they're using NQF-endorsed measures.

Nicole Silverman, Vice President, Program Operations, introduced the eMeasures team. This team focused on accelerating eMeasurement. The team pointed out that gaps in knowledge exist across stakeholders involved in eMeasurement. For example, developers may not know the right data elements to include in an eMeasure and electronic health records vendors may not be familiar with quality measurement. The team suggested the following approaches to the knowledge issue:

1. Extending the existing eMeasure Collaborative to bring all the stakeholders together as a forum for problem solving;
2. Expanding the eMeasure Collaborative by creating an online collaboration space and creating user groups to delve deeply into particular areas of interest and then bring that back to the larger group;

3. Expanding participation in the eMeasure Collaborative to include professional societies like HIMSS, HL7 and possibly registries; and
4. Looking at ways for the eMeasure Collaborative to be self-sustaining.

Wendy Vernon, Senior Director, National Priorities, introduced the affordability team. This team noted the need to focus on a definition of affordability as it may vary widely among stakeholders. The team suggested creating a collaborative incubation space to create a pathway or blueprint to define affordability, identify who is working on it, what problems they encounter, and how implementation is progressing.

Gerry Shea asked for the Board's advice on whether these priority activities are suitable for NQF and if the Board liked what the teams suggested. The Board stated that it liked bringing the pieces of NQF together through this strategic planning process and reinforced that this should continue to happen. The Board was very appreciative of the teams' work.

Many Board members stated that NQF's first priority should be affordability and value of health care. Quality and affordability should be dealt with together, not separately. NQF should find out what communities are trying to work on and focus on actual barriers to implementation. To improve affordability, NQF should look beyond measures to general resource use and appropriateness. When talking about affordability, NQF should also be clear about answering the question, "Affordability for whom?" Affordability trumps other issues and if we don't define affordability it will be difficult to get people's attention on quality.

The Board also noted the need for identifying and prioritizing gaps, as well as encouraging gap filling. NQF must clarify its role in this space and consider how the measures will be used. Developers should not be NQF's only focus in dealing with this issue.

The Board commended NQF's strategy work, but also encouraged NQF to be realistic about how much it can accomplish. NQF will need to decide which projects to pursue wholeheartedly and which projects should be nudged along, possibly with a partner.

Other Board suggestions for NQF's strategic planning include:

1. More work on tracking how measures are used and how well they are used;
2. Meaningful engagement of clinicians and patients on what questions they want answered, which will result in engagement and use of NQF outputs;
3. Inclusion of patient voices in quality measurement and creation of measures on patient decision quality;
4. Creation of a more specific roadmap for correctly measuring performance, value, and cost;
5. Reduction of measurement burden;

6. Addition of a national quality measurement award to recognize achievement in the field; and
7. More focus on outcomes in the strategic plan and less of a process focus.

ACTION: The Board approved the strategic initiatives with modifications suggested by the Board.

Congressional Reauthorization (TAB 2)

Chip Kahn updated the Board on Stand for Quality (SFQ), which is now led by Mr. Kahn and Debra Ness. Stand for Quality has two efforts underway: (1) furthering the quality enterprise by securing funding for NQF's endorsement work, for the MAP in terms of reviewing what CMS does, and NPP for advising HHS on priorities, and (2) securing measure development funding. SFQ has put together a 5-year proposal to replace the MIPPA money for funding of endorsement and also replace money for MAP and NPP. The proposal also covers pursuing trust fund dollars to support measure development. Mr. Kahn then described the work done on the Hill to secure funding.

Mr. Kahn and Ms. Ness were cautiously optimistic about the chances of securing funding and noted that NQF's fate is tied to the bigger picture surrounding the fiscal cliff. They emphasized the importance of a single consistent message as NQF seeks funding.

The Board discussed its responsibility to work with people we know are not happy with NQF and encourage them to bring their grievances to NQF rather than airing them elsewhere.

Performance Measures Update (TAB 3)

Helen Burstin updated the Board on performance measures activity. NQF is reviewing updates to the readmission measures and is seeking public comment on those updates. NQF has also provided materials regarding unintended consequences of measurement.

Larry Becker discussed the work of the Consensus Task Force. Focus groups were convened to get a handle on the issues surrounding the consensus process. Heidi Bossley described the work as being divided into items that (1) don't require revision to the consensus development process (CDP) but could help and be immediately responsive, and (2) items that do require CDP revision. The items that do not require CDP revision were identified primarily by focus groups and included suggestions about consistent handling of matters brought before steering committees and member engagement, especially through adjusting the comment period.

Items that require CDP revision may need to move on a slower timeline in order to thoroughly vet suggestions. For example, NQF wants detailed input on the definition of achieving consensus, e.g., do we achieve it overall or do we achieve it at each step? The Task Force will also come up with several scenarios on voting, which is related to achieving consensus.

The Board noted the need for consumer involvement and Deborah Ness volunteered to recruit consumer voices for this process.

Strategic Partnerships Update (TAB 4)

Dr. Tom Valuck, Senior Vice President, Strategic Partnerships, discussed enhancements to NQF's pre-rulemaking process. The process is much different than last year and will use the following four-step approach:

Step 1: Build on MAP's prior recommendations.
Step 2: Evaluate each currently finalized program measure set using MAP Measure Selection Criteria.
Step 3: Evaluate measures under consideration for what they would add to the program measure sets.
Step 4: Identify high-priority measure gaps for programs and settings.

Dr. Valuck identified several items that are new for the pre-rulemaking process for 2013 reports:

1. New information inputs, including families of measures, use of measures in public and private sector programs for information on use and alignment, and performance results to determine measure impact;
2. "Homework" assignments for work group members in advance of meetings to allow the discussions to start at a deeper level; and
3. More granular recommendations and more detail in the report.

Dr. Valuck noted that one of the challenges is that the pre-rulemaking workload for NQF continues to grow, but the time allotted to do the work remains the same.

Dr. Valuck introduced the National Priorities Partnership (NPP) 2013 slate, which was reviewed by the Board and approved for posting for public comment. No public comments were received and Dr. Valuck asked for Board to finalize the NPP slate.

ACTION: The Board approved the 2013 slate for the National Priorities Partnership, as follows:
Voting Partners are AARP; AFL-CIO; Aligning Forces for Quality; Alliance for Home Health Quality and Innovation; Alliance for Pediatric Quality; America's Health Insurance Plans; American Board of Medical Specialties; American Health Care Association; American Medical Association; American Medical Informatics Association; American Nurses Association; Association of State and Territorial Health Officials; Certification Commission for Health Information Technology; Consumers Union; Council of Medical Specialty Societies; Dartmouth-Hitchcock; Health Information and Management Systems

Society; Hospice and Palliative Care Coalition; Independence Blue Cross; Institute for Healthcare Improvement; Johnson & Johnson Health Care Systems, Inc.; The Joint Commission; Leapfrog Group; March of Dimes; National Association of Community Health Centers; National Association of Public Hospitals and Health Systems; National Association of State Medicaid Directors; National Business Group on Health; National Committee for Quality Assurance; National Hispanic Medical Association; National Initiative for Children's Healthcare Quality; National Partnership for Women & Families; National Quality Forum; Network for Regional Healthcare Improvement; Nursing Alliance for Quality Care; Pacific Business Group on Health; Partnership for Prevention; Patient Centered Primary Care Collaborative; Pharmacy Quality Alliance; Physician Consortium for Performance Improvement; Planetree; and U.S. Chamber of Commerce.

Ex Officio, Non-Voting Partners are Agency for Healthcare Research and Quality; Centers for Disease Control and Prevention; Centers for Medicare & Medicaid Services; Department of Veterans Affairs/Veterans Health Administration; Health Resources and Services Administration; National Institutes of Health; Substance Abuse and Mental Health Services Administration; U.S. Food and Drug Administration; and U.S. Office of Personnel Management.

Dr. Bill Roper, Board Chair, told the Board to expect an invitation to a call next week to discuss the CEO search and then expect to have a time organized in February or March when the Board can talk strategy and include the CEO designate.

There were no comments from the public regarding any of the Board's discussions.

The Board considered no other business and the meeting adjourned at 2:29 p.m.

Respectfully submitted,

Ann F. Hammersmith
Corporation Secretary

FUTURE BOARD MEETINGS

2013	2014
May 16	May 15
September 19	September 18
December 5	December 4

STRATEGIC PLANNING MEETINGS

2013
April 23-24
May 15
July 22

NATIONAL QUALITY FORUM

TO: NQF Board of Directors

FR: NQF Member Relations Team

DA: May 7, 2013

RE: Member Relations Update

As of May 7, 2013, 2012, NQF has a total of 421 members. To date:

- Ten (10) new members have been approved;
- Eighteen (18) members have been cancelled since January 2013

2013 Year-to-Date NQF Membership Overview

Member Councils	YTD Total Members
Consumer Council	30
Health Professionals Council	102
Public/Community Health Agencies Council	27
Purchaser Council	19
Health Plan Council	17
Provider Organization Council	118
Quality, Measurement, Research and Improvement Council (QMRI)	73
Supplier & Industry Council	35
Subtotal	**421**

NQF Membership Growth Annual Overview

	Start of Year	New Members	Cancelled	Year End Totals
2013	429	10	18	421 (-1.8%)
2012	435	33	39	429 (net -1.37%)
2011	421	53	39	435 (net 3.3%)
2010	383	54	17	420 (net +9.7%)
2009	359	62	38	383 (net+6.7%)
2008	350	45	54	359 (net +2.6%)

2013 New Members Year-to-Date

Organization	Council
Academic Consortium for Complementary and Alternative Health Care	Health Professional
Alliance of Wound Care Stakeholders	Health Professional
Association of State and Territorial Health Officials	Public/Community Health Agency
Greater New York Hospital Association	Provider
Israel National Program for Quality Indicators in Health Care	QMRI
Mathematica Policy Research	QMRI
Puget Sound Health Alliance	Public/Community Health Agency
SAS Institute	Supplier & Industry
Syus, Inc	QMRI
WellCare Health Plans, Inc.	Health Plans

2013 Cancelled Members

Ada County Paramedics
Baptist Health South Florida
Community Connections of New York, Inc.
Genesis HealthCare System
Good Samaritan Hospital
Group Health Cooperative
Healthcare Supply Chain Association
HealthGrades
Horizon Blue Cross Blue Shield of New Jersey
Issio Solutions, Inc.
MedeAnalytics, Inc.
National Academy of Clinical Biochemistry
National Association of Dental Plans
National Breast Cancer Coalition
Park Nicollet Health Services
Phytel, Inc.
Trust for America's Health
Truven Health Analytics

Members cite budget/economic, ROI and limited staff resources as primary reasons for cancelling. In cases where appropriate, staff extend the opportunity to organizations to apply for dues reduction due to hardship.