NATIONAL QUALITY FORUM

Cost and Efficiency Spring 2018 Measure Review Cycle

Standing Committee Measure Evaluation Tutorial Web Meeting

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Welcome

NQF Staff

- Project staff
  - *Erin O'Rourke, Senior Director*
  - *Kate McQueston, Senior Project Manager*
  - *Vanessa Moy, Project Analyst*
  - *Taroon Amin, Consultant*
- NQF Quality Measurement leadership staff
  - *Elisa Munthali, Senior Vice President*

Agenda for the Call

- Welcome
- Overview of NQF, the CDP, and Roles
- Overview of NQF's Cost and Efficiency Portfolio
- Measure Prioritization Initiative
- Measure Evaluation Criteria Overview
- Public comment
- Next steps

Standing Committee

- Brent Asplin, MD, MPH (co-chair)
- Cheryl Damberg, PhD (co-chair)
- Kristine Martin Anderson, MBA
- Larry Becker
- Mary Ann Clark, MHA
- Troy Fiesinger, MD, FAAFP
- Nancy Garrett, PhD
- Andrea Gelzer, MD, MS, FACP
- Rachael Howe, MS, BSN, RN
- Jennifer Eames Huff, MPH, CPEH
- Sunny Jhamnani, MD
- Lisa Latts, MD, MSPH, MBA, FACP
- Jason Lott, MD, MHS, MSHP, FAAP
- Martin Marciniak, MPP, PhD
- James Naessens, ScD, MPH
- Jack Needleman, PhD
- Janis Orlowski, MD, MACP
- Carolyn Pare
- John Ratliff, MD, FACS, FAANS
- Andrew Ryan, PhD *(Inactive 2017-2018)*
- Srinivas Sridhara, PhD, MHS
- Lina Walker, PhD
- Bill Weintraub, MD, FACC
- Herbert Wong, PhD
- Dolores Yanagihara, MPH

Overview of NQF, the CDP, and Roles

The National Quality Forum: A Unique Role

Established in 1999, NQF is a nonprofit, nonpartisan, membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare performance measurement. The goal is to make healthcare in the U.S. better, safer, and more affordable.

Mission: To lead national collaboration to improve health and healthcare quality through measurement

- An Essential Forum
- Gold Standard for Quality Measurement
- Leadership in Quality

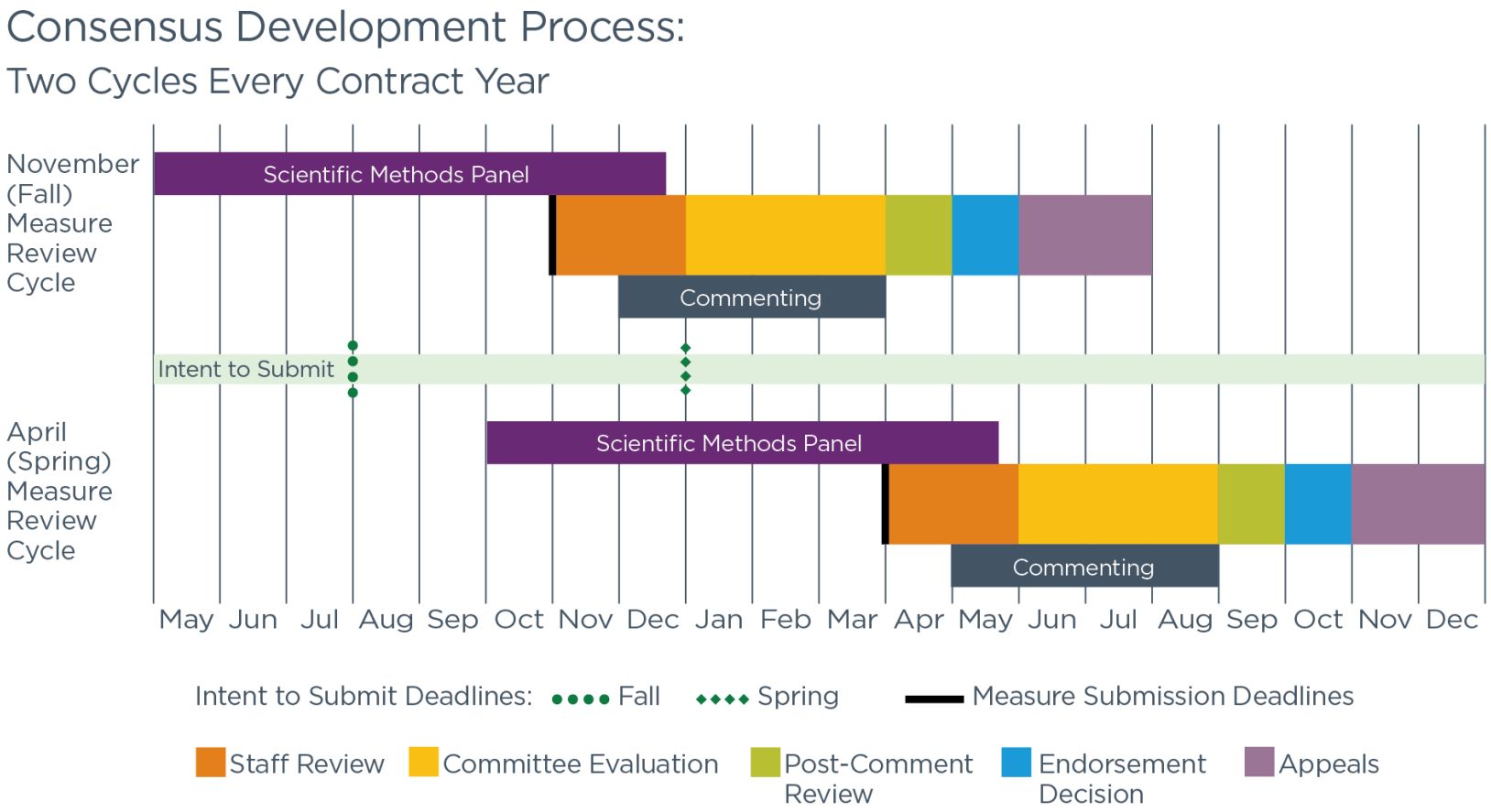
NQF Activities in Multiple Measurement Areas

- **Performance Measure Endorsement**
  - *600+ NQF-endorsed measures across multiple clinical areas*
  - *15 empaneled standing expert committees*
- **Measure Applications Partnership (MAP)**
  - *Advises HHS on selecting measures for 20+ federal programs*
- **National Quality Partners**
  - *Convenes stakeholders around critical health and healthcare topics*
  - *Spurs action: recent examples include antibiotic stewardship, advanced illness care, shared decision making, and opioid stewardship*
- **Measurement Science**
  - *Convenes private and public sector leaders to reach consensus on complex issues in healthcare performance measurement*
    - » Examples include HCBS, rural issues, telehealth, interoperability, attribution, risk-adjustment for social risk factors, diagnostic accuracy, disparities
- **Measure Incubator**
  - *Facilitates efficient measure development and testing through collaboration and partnership*

NQF Consensus Development Process (CDP)
6 Steps for Measure Endorsement

- Intent to Submit
- Call for Nominations
- Measure Evaluation
  - *New structure/process*
  - *Newly formed NQF Scientific Methods Panel*
  - *Measure Evaluation Technical Report*
- Public Commenting Period with Member Support
- Measure Endorsement
- Measure Appeals

Measure Review: Two Cycles Per Year



15 New Measure Review Topical Areas

	All Cause Admission/ Readmissions	Behavioral Health	
Cancer	Cardiovascular	Care Coordination	Infectious Disease
Cost and Resource Use	Endocrine	Eyes, Ears, Nose and Throat Conditions	Palliative and End-of Life Care
Gastrointestinal	Genitourinary	Health and Well Being	Musculoskeletal
Neurology	Patient Safety	Pediatrics	Perinatal
Person and Family-Centered Care	Pulmonary and Critical Care	Renal	Surgery

All Cause Admission/ Readmissions	Behavioral Health & Substance Use	Cancer
Cardiovascular	Cost and Efficiency[A]	Geriatric and Palliative Care[B]
Neurology	Patient Experience & Function	Patient Safety[C]
Pediatrics	Perinatal and Women's Health	Prevention and Population Health[D]
Primary Care and Chronic Illness	Renal	Surgery

☐ Denotes expanded topic area

[A] Cost & Efficiency will include efficiency-focused measures from other domains
[B] Geriatric & Palliative Care includes pain-focused measures from other domains
[C] Patient Safety will include acute infectious disease and critical measures
[D] Prevention and Population Health is formerly Health and Well Being

Role of the Standing Committee
General Duties

- Act as a proxy for the NQF multistakeholder membership
- Serve 2-year or 3-year terms
- Work with NQF staff to achieve the goals of the project
- Evaluate candidate measures against the measure evaluation criteria
- Respond to comments submitted during the review period
- Respond to any directions from the CSAC

Role of the Standing Committee
Measure Evaluation Duties

- All members evaluate ALL measures
- Evaluate measures against each criterion
  - *Indicate the extent to which each criterion is met and rationale for the rating*
- Make recommendations to the NQF membership for endorsement
- Oversee the all-cause admissions and readmissions portfolio of measures
  - *Promote alignment and harmonization*
  - *Identify gaps*

Role of the Standing Committee Co-Chairs

- Co-facilitate Standing Committee (SC) meetings
- Work with NQF staff to achieve the goals of the project
- Assist NQF in anticipating questions and identifying additional information that may be useful to the SC
- Keep SC on track to meet goals of the project without hindering critical discussion/input
- Represent the SC at CSAC meetings
- Participate as a SC member

Role of NQF Staff

- NQF project staff works with SC to achieve the goals of the project and ensure adherence to the consensus development process:
  - *Organize and staff SC meetings and conference calls*
  - *Guide the SC through the steps of the CDP and advise on NQF policy and procedures*
  - *Review measure submissions and prepare materials for Committee review*
  - *Draft and edit reports for SC review*
  - *Ensure communication among all project participants (including SC and measure developers)*
  - *Facilitate necessary communication and collaboration between different NQF projects*

Role of NQF Staff
Communication

- Respond to NQF member or public queries about the project
- Maintain documentation of project activities
- Post project information to NQF's website
- Work with measure developers to provide necessary information and communication for the SC to fairly and adequately evaluate measures for endorsement
- Publish final project report

Role of Methods Panel

- Scientific Methods Panel created to ensure higher-level and more consistent reviews of the scientific acceptability of measures

- The Methods Panel is charged with:
  - *Conducting evaluation of complex measures for the Scientific Acceptability criterion, with a focus on reliability and validity analyses and results*
  - *Serve in advisory capacity to NQF on methodologic issues, including those related to measure testing, risk adjustment, and measurement approaches.*

- The Methods Panel review will help inform the standing committee's endorsement decision. The panel will not render endorsement recommendations.

Role of the Expert Reviewers

- In 2017, NQF executed a CDP redesign that resulted in restructuring and reducing the number of topical areas as well as a bi-annual measure review process.
- Given these changes, there is a need for diverse yet specific expertise to support longer and continuous engagement from standing committees.

Role of the Expert Reviewers

- The expert reviewer pool serves as an adjunct to NQF standing committees to ensure broad representation and provide technical expertise when needed
- Expert reviewers will provide expertise as needed to review measures submitted for endorsement consideration by:
  - *replacing an inactive committee member;*
  - *replacing a committee member whose term has ended; or*
  - *providing expertise that is not currently represented on the committee.*
- Expert reviewers may also:
  - *Provide comments and feedback on measures throughout the measure review process*
  - *Participate in strategic discussions in the event no measures are submitted for endorsement consideration*

NQF Consensus Development Process (CDP)
Measure Evaluation

Complex Measures

- **Outcome measures, including intermediate clinical outcomes**
- **Instrument-based measures (e.g., PRO-PMs)**
- **Cost/resource use measures**
- **Efficiency measures (those combining concepts of resource use and quality)**
- **Composite measures**

Noncomplex Measures

- **Process measures**
- **Structural measures**
- **Previously endorsed complex measures with no changes/updates to the specifications or testing**

Questions?

Overview of NQF's Cost and Efficiency Portfolio and Prioritization Initiative

Cost and Efficiency Portfolio of Measures

- This project will evaluate measures related to cost and efficiency that can be used for accountability and public reporting for all populations and in all settings of care.
- NQF solicits new measures for possible endorsement
- Endorsed measures undergo periodic evaluation to maintain endorsement—"maintenance."

Cost and Efficiency Portfolio of Measures Under Review

Measures for maintenance evaluation

Transitions or Handoffs

- 0496 Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients

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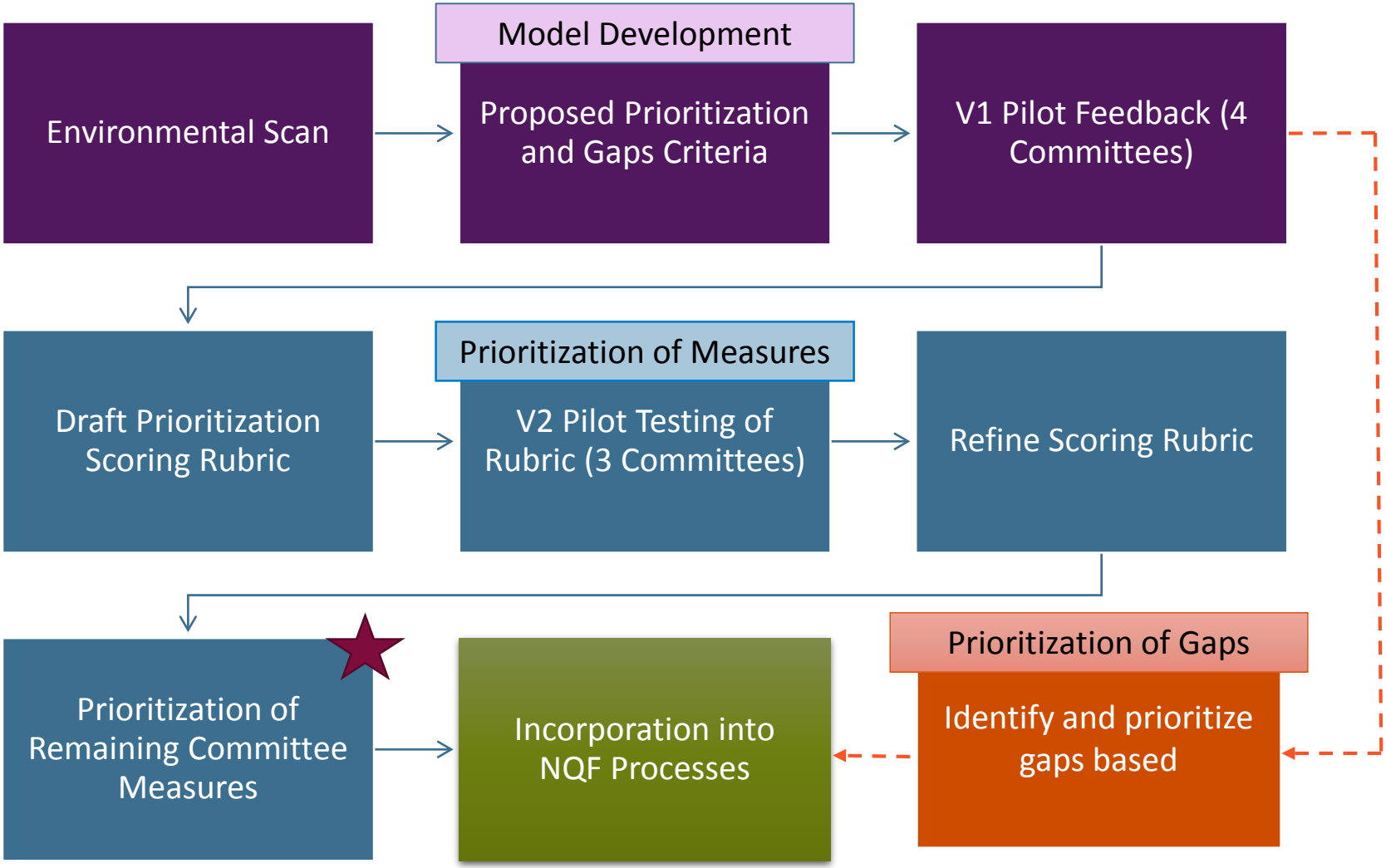
NQF Prioritization Initiative

NQF's Strategic Direction

Learn more about NQF's Strategic Plan at
http://www.qualityforum.org/NQF_Strategic_Direction_2016-2019.aspx

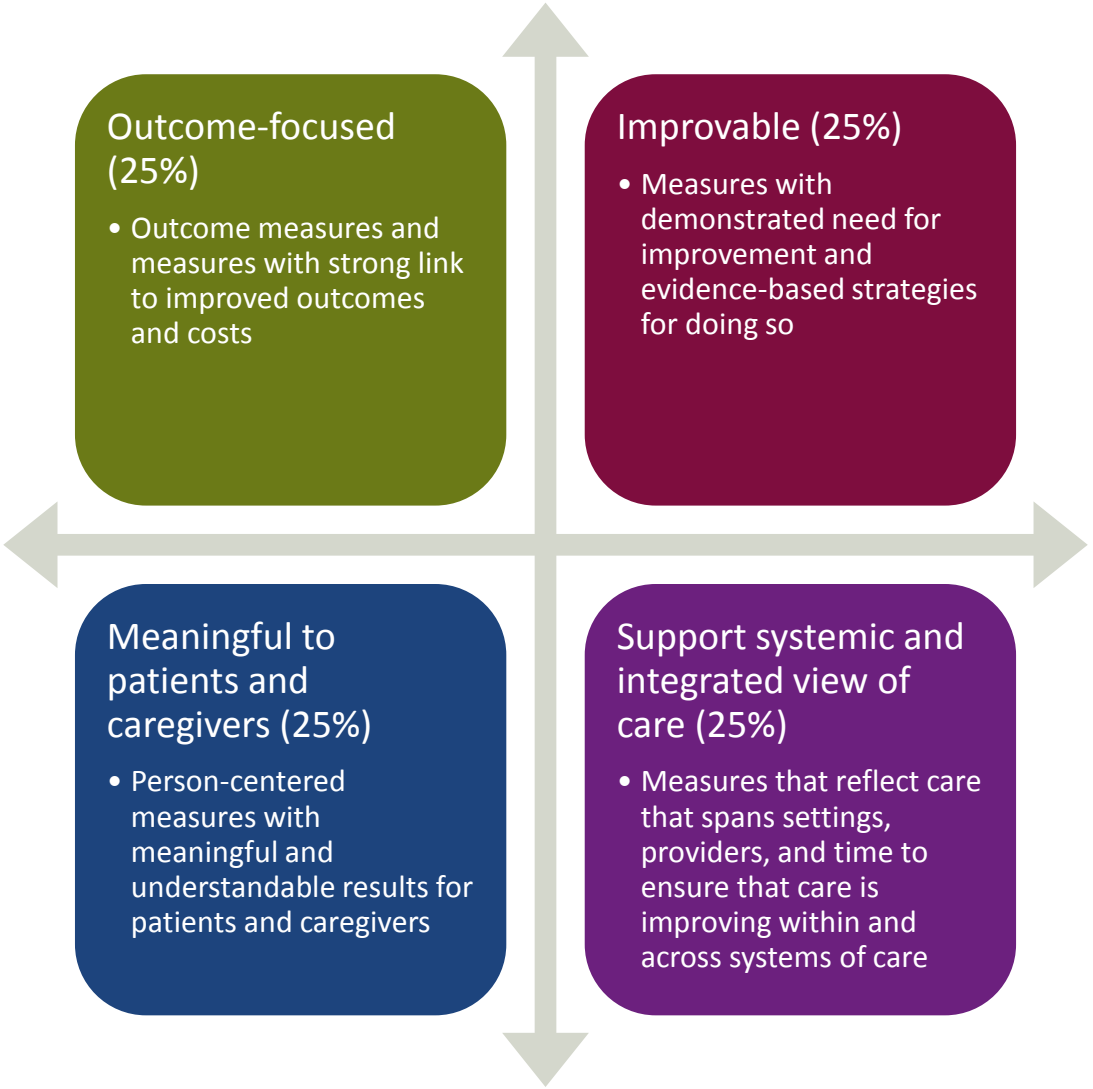
NQF Prioritization Initiative



NQF Measure Prioritization Criteria

Prioritization Phase 1

Prioritization Phase 2



Outcome-focused (25%)

- Outcome measures and measures with strong link to improved outcomes and costs

Improvable (25%)

- Measures with demonstrated need for improvement and evidence-based strategies for doing so

Meaningful to patients and caregivers (25%)

- Person-centered measures with meaningful and understandable results for patients and caregivers

Support systemic and integrated view of care (25%)

- Measures that reflect care that spans settings, providers, and time to ensure that care is improving within and across systems of care

Equity Focused

- Measures that are disparities sensitive

Breakdown of the Criteria

Outcome-focused

- Measures are scored based on measure type: Process/Structural, Intermediate clinical outcome or process tightly linked to outcome, Outcome/CRU

Improvable

- Measures are scored based the percentage of committee members votes on the "Gap" Criteria during measure evaluation and maintenance review for "High," "Moderate," or "Low."

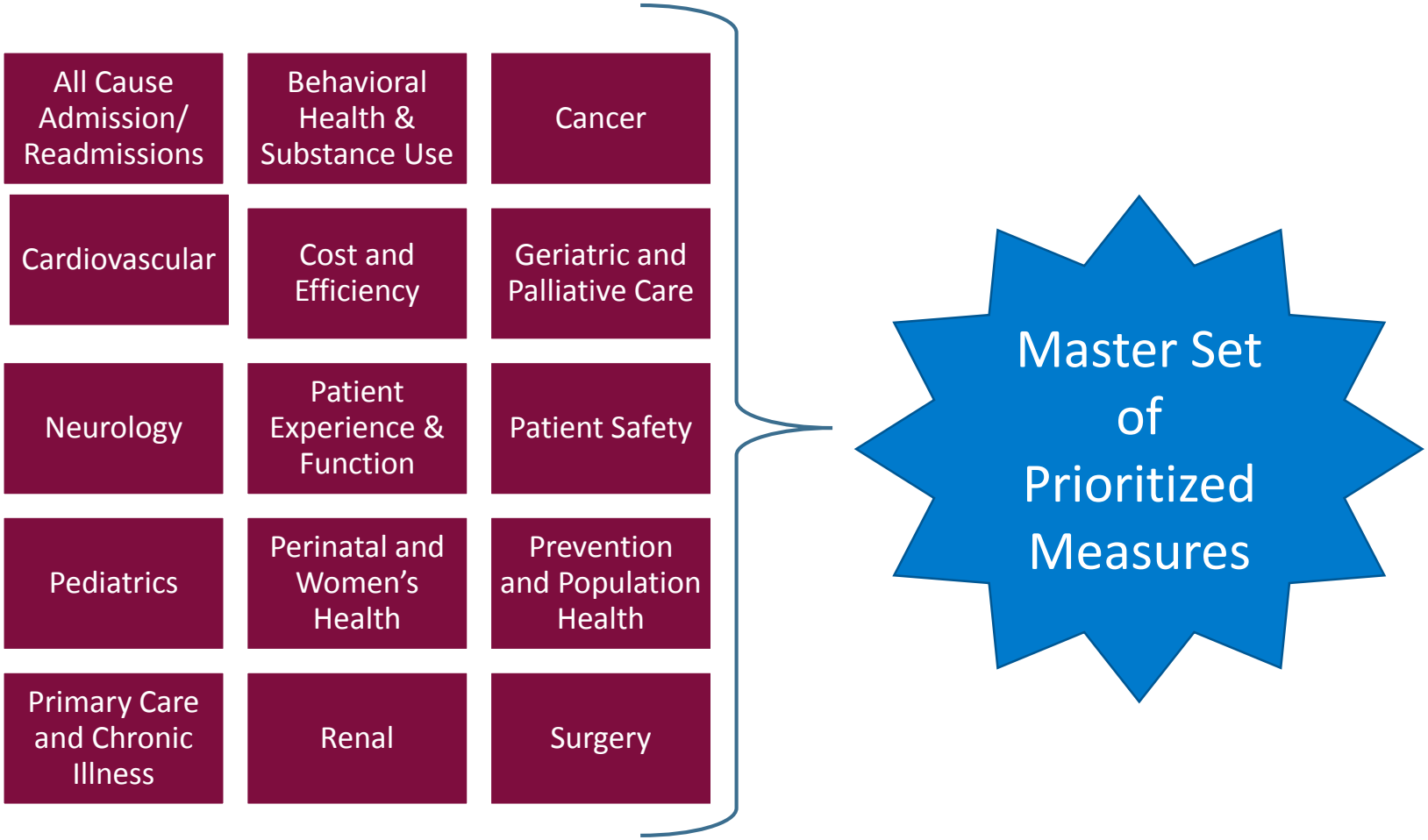
Meaningful to patients and caregivers

- Measures are scored based on if they are (1) a PRO and (2) if they are tagged as meaningful to patients.
- A meaningful change or health maintenance to the patients and caregivers encompasses measures that address the following areas: symptoms, functional status, health related quality of life or well-being. Patient and caregiver experience of care (Including financial stress, satisfaction, care coordination/continuity of care wait times, Patient and caregiver autonomy/empowerment) and harm to the patient, patient safety, or avoidance of an adverse event.

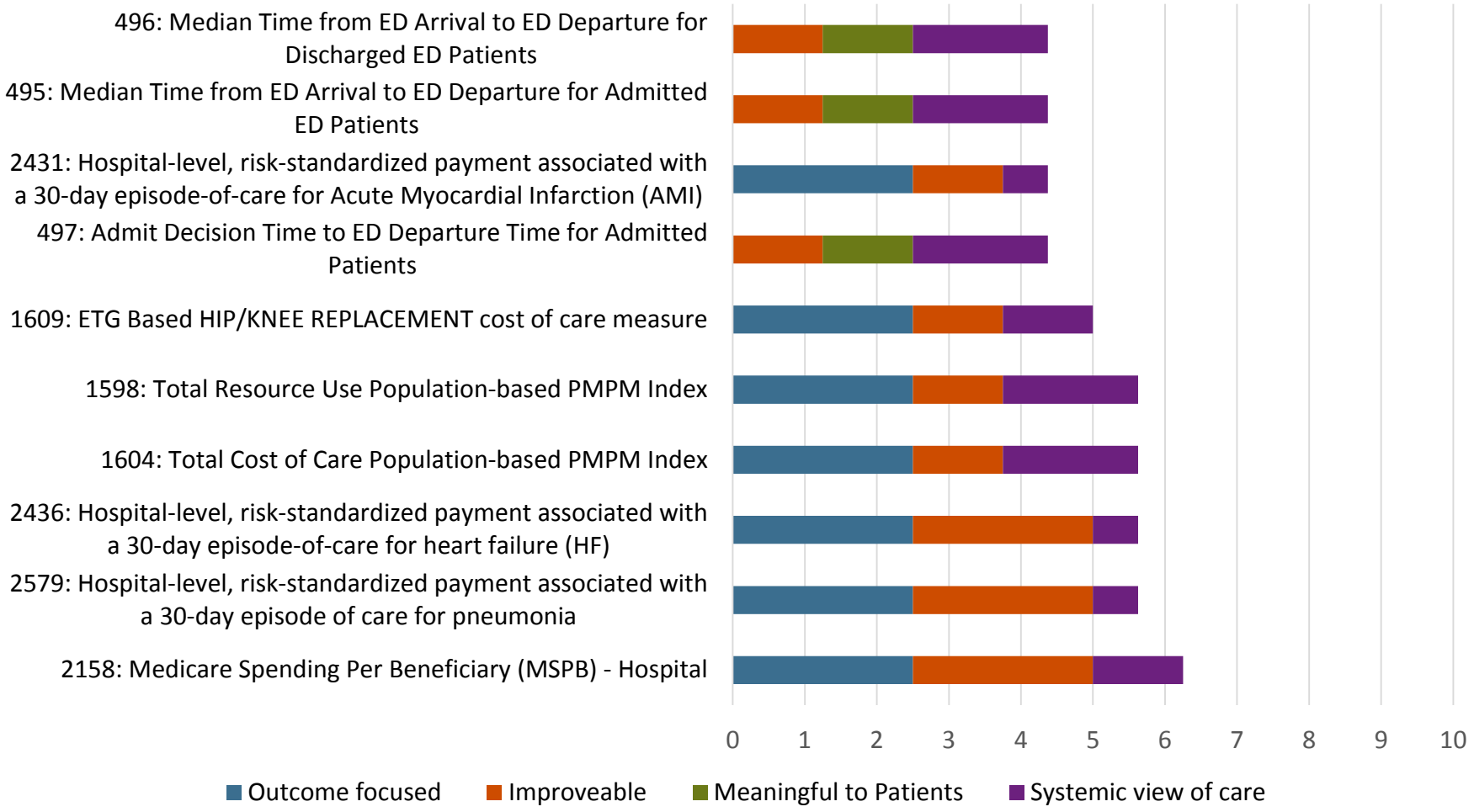
Support systemic and integrated view of care

- Measures are scored based on if (1) if they are a composite measure, (2) if they are applicable to multiple settings, (3) if they are condition agnostic, and (4) if they reflect a system outcome.
- A system outcome is defined as a measure that: addresses issues of readmission, addresses issues of care-coordination, results from the care of multiple providers, or addresses aspects to enhance healthcare value (including a cost or efficiency component)

Prioritization will be conducted within and across portfolios



Cost and Efficiency Portfolio Prioritization Scoring



NQF Prioritization Initiative: What's Next?

Activity	Date
Roll out at spring 2018 standing committee meetings	May-June 2018
Compile phase I results from across committees	June-August 2018
Measure evaluation annual report appendix	September 2018
Presentation/update at NQF annual meeting	March 2019

Questions for Committee

- Do the initial scoring results yield the outcomes you might have expected?
  - *Are the highest and lowest impact measures scoring correctly based on the rubric?*
  - *Do you have any feedback on the way the rubric is generating results or suggestions for updates in future iterations?*
- Survey to be sent by email following the presentation.

Measure Evaluation Criteria Overview

NQF Measure Evaluation Criteria for Endorsement

NQF endorses measures for accountability applications (public reporting, payment programs, accreditation, etc.) as well as quality improvement.

- Standardized evaluation criteria
- Criteria have evolved over time in response to stakeholder feedback
- The quality measurement enterprise is constantly growing and evolving—greater experience, lessons learned, expanding demands for measures—the criteria evolve to reflect the ongoing needs of stakeholders

Major Endorsement Criteria *(page 28)*

- **Importance to measure and report**: Goal is to measure those aspects with greatest potential of driving improvements; if not important, the other criteria are less meaningful (***must-pass***)
- **Reliability and Validity-scientific acceptability of measure properties**: Goal is to make valid conclusions about quality; if not reliable and valid, there is risk of improper interpretation (***must-pass***)
- **Feasibility**: Goal is to, ideally, cause as little burden as possible; if not feasible, consider alternative approaches
- **Usability and Use**: Goal is to use for decisions related to accountability and improvement; if not useful, probably do not care if feasible
- **Comparison to related or competing measures**

Criterion #1: Importance to Measure and Report (page 30-39)

1. Importance to measure and report - Extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality where there is variation in or overall less-than-optimal performance.

1a. Evidence: *the measure focus is evidence-based*

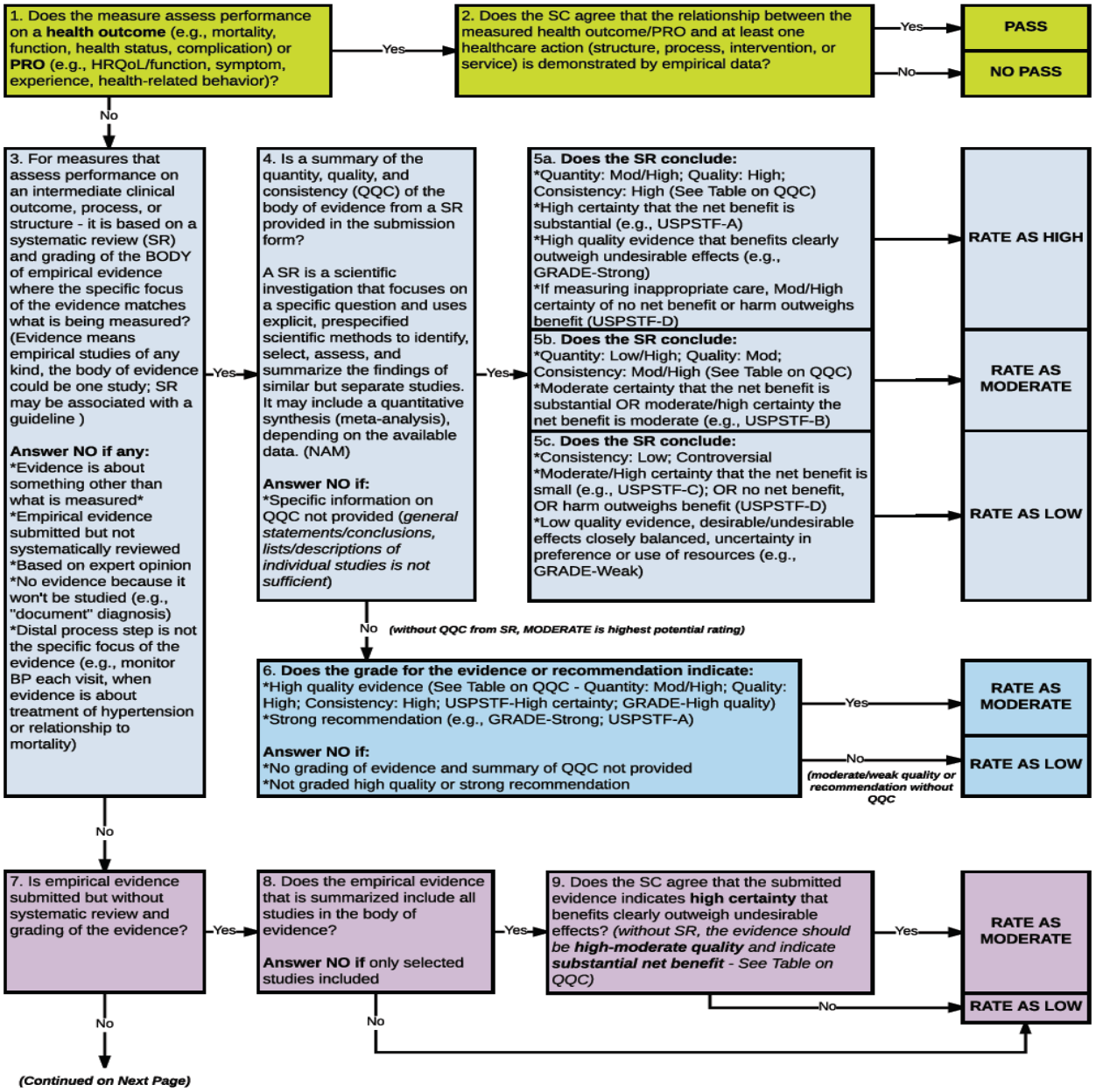
1b. Opportunity for Improvement: *demonstration of quality problems and opportunity for improvement, i.e., data demonstrating considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or disparities in care across population groups*

1c. Quality construct and rationale *(composite measures only)*

Subcriteron 1a: Evidence (page 31-37)

- Outcome measures
  - *Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias.*
- Structure, process, intermediate outcome measures
  - *The quantity, quality, and consistency of the body of evidence underlying the measure should demonstrate that the measure focuses on those aspects of care known to influence desired patient outcomes*
    - » Empirical studies (expert opinion is not evidence)
    - » Systematic review and grading of evidence
      - *Clinical Practice Guidelines – variable in approach to evidence review*
- For measures derived from patient (or family/parent/etc.) report
  - *Evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful.*
  - *Current requirements for structure and process measures also apply to patient-reported structure/process measures.*

Rating Evidence: Algorithm #1 – page 34



Criterion #1: Importance to measure and report Criteria emphasis is different for new vs. maintenance measures

New measures	Maintenance measures
• Evidence – Quantity, quality, consistency (QQC) • Established link for process measures with outcomes	**DECREASED EMPHASIS**: Require measure developer to attest evidence is unchanged evidence from last evaluation; Standing Committee to affirm no change in evidence IF changes in evidence, the Committee will evaluate as for new measures
• Gap – opportunity for improvement, variation, quality of care across providers	**INCREASED EMPHASIS**: data on current performance, gap in care and variation

Criterion #2: Reliability and Validity–Scientific Acceptability of Measure Properties (page 39 - 48)

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of health care delivery

2a. **Reliability (must-pass)**

2a1. Precise specifications including exclusions

2a2. Reliability testing—data elements or measure score

2b. **Validity (must-pass)**

2b1. Validity testing—data elements or measure score

2b2. Justification of exclusions—relates to evidence

2b3. Risk adjustment—typically for outcome/cost/resource use

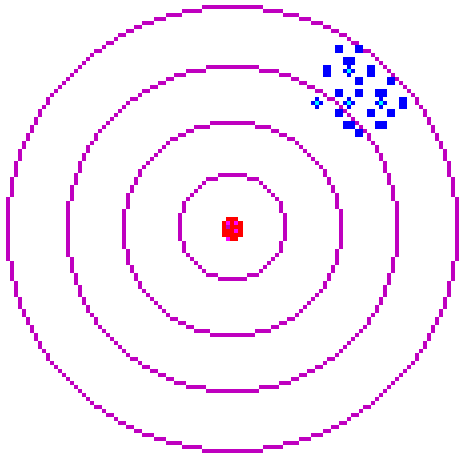
2b4. Identification of differences in performance

2b5. Comparability of data sources/methods

2b6. Missing data

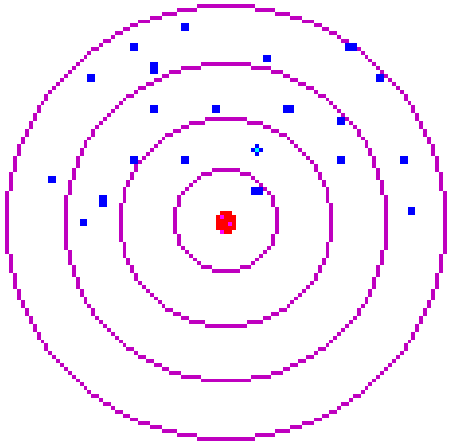
Reliability and Validity (page 40)

Assume the center of the target is the true score…



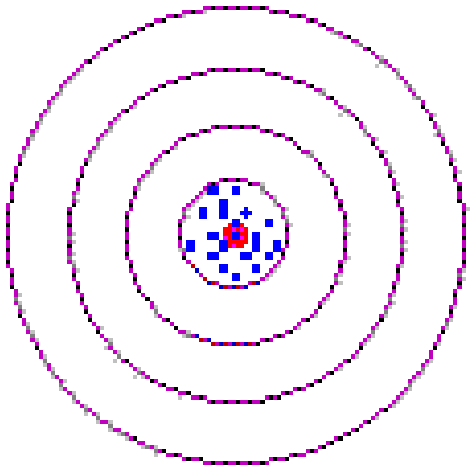
Reliable Not Valid

Consistent, but wrong



Neither Reliable Nor Valid

Inconsistent & wrong



Both Reliable And Valid

Consistent & correct

Evaluating Scientific Acceptability – Key Points (page 41)

Empirical analysis to demonstrate the reliability and validity of the *measure as specified,* including analysis of issues that pose threats to the validity of conclusions about quality of care such as exclusions, risk adjustment/stratification for outcome and resource use measures, methods to identify differences in performance, and comparability of data sources/methods.

Reliability Testing
Key points - page 42

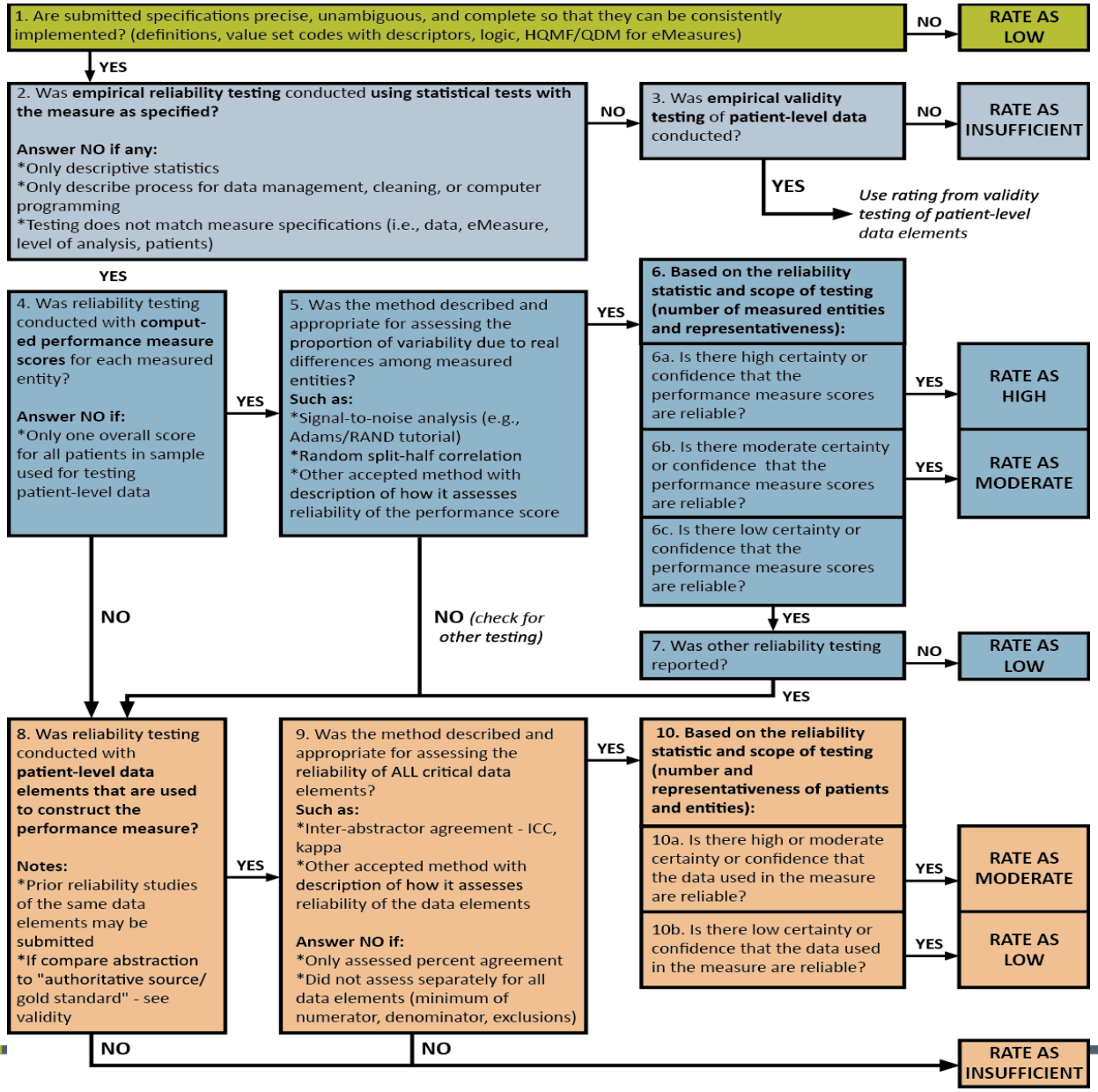
- Reliability of the ***measure score*** refers to the proportion of variation in the performance scores due to systematic differences across the measured entities in relation to random variation or noise (i.e., the precision of the measure).
  - *Example - Statistical analysis of sources of variation in performance measure scores (signal-to-noise analysis)*

- Reliability of the ***data elements*** refers to the repeatability/ reproducibility of the data and uses patient-level data
  - *Example – inter-rater reliability*

- Consider whether testing used an appropriate method and included adequate representation of providers and patients and whether results are within acceptable norms

- Algorithm #2

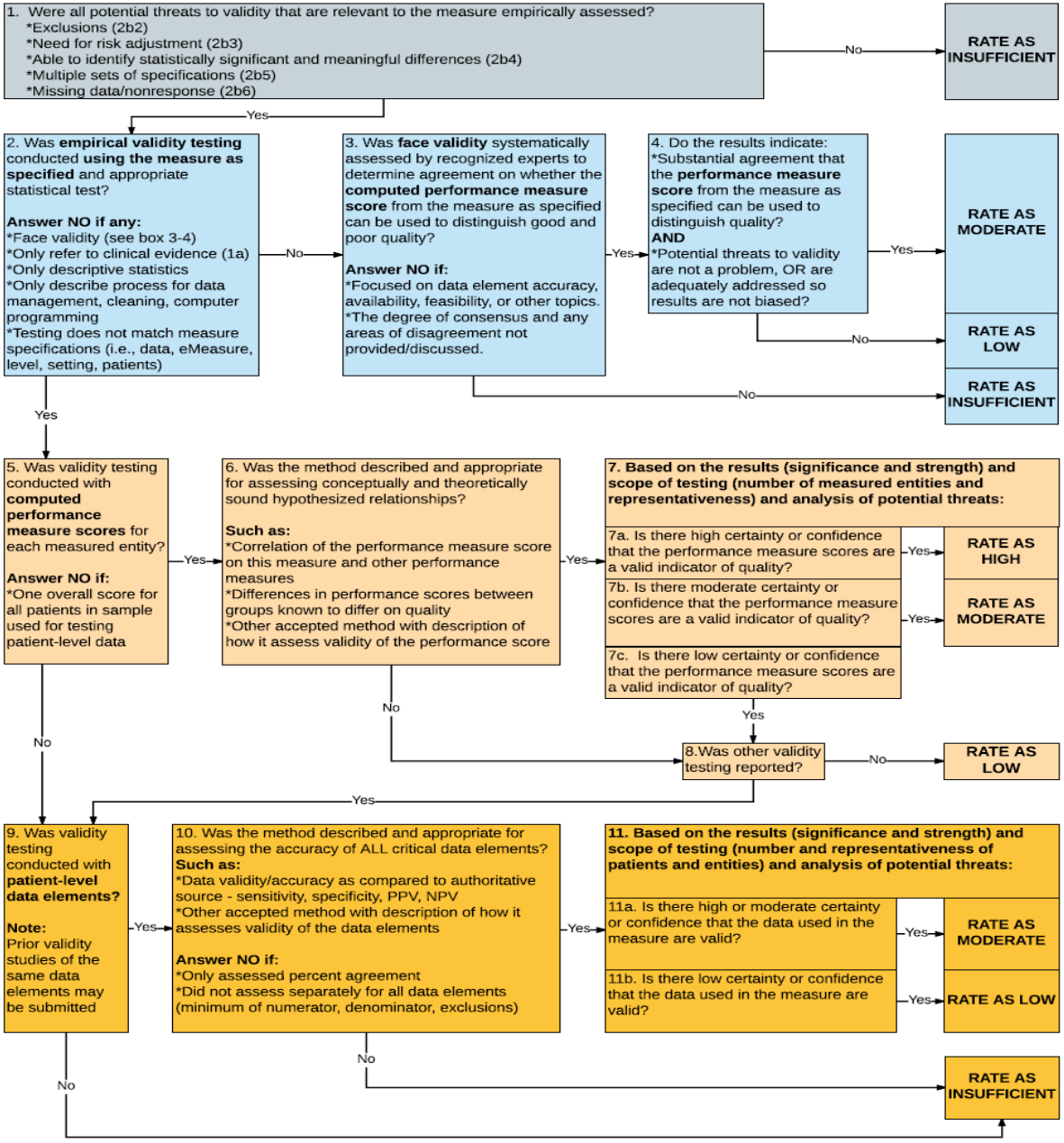
Rating Reliability: Algorithm #2 – page 43



Validity testing (pages 44 - 49)
Key points – page 47

- **Empirical testing**
  - *Measure score* – assesses a hypothesized relationship of the measure results to some other concept; assesses the correctness of conclusions about quality
  - *Data element* – assesses the correctness of the data elements compared to a "gold standard"
- **Face validity**
  - *Subjective determination by experts that the measure appears to reflect quality of care*
    - » Empirical validity testing is expected at time of maintenance review; if not possible, justification is required.
    - » Requires systematic and transparent process, by identified experts, that explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.

Rating Validity: Algorithm #3 – page 48



Threats to Validity

- Conceptual
  - *Measure focus is not a relevant outcome of healthcare or not strongly linked to a relevant outcome*
- Unreliability
  - *Generally, an unreliable measure cannot be valid*
- Patients inappropriately excluded from measurement
- Differences in patient mix for outcome and resource use measures
- Measure scores that are generated with multiple data sources/methods
- Systematic missing or “incorrect” data (unintentional or intentional)

Criterion #2: Scientific Acceptability

New measures	Maintenance measures
• Measure specifications are precise with all information needed to implement the measure	NO DIFFERENCE: Require updated specifications
• Reliability • Validity (including risk-adjustment)	**DECREASED EMPHASIS**: If prior testing adequate, no need for additional testing at maintenance with certain exceptions (e.g., change in data source, level of analysis, or setting) Must address the questions regarding use of social risk factors in risk-adjustment approach

Criterion #3: Feasibility (page 49)
Key Points – page 50

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

3a: Clinical data generated during care process

3b: Electronic sources

3c: Data collection strategy can be implemented

Criterion #4: Usability and Use (page 50) Key Points – page 51

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

Use (4a) Now must-pass for maintenance measures

4a1: Accountability and Transparency: *Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement.*

4a2: Feedback by those being measured or others: *Those being measured have been given results and assistance in interpreting results; those being measured and others have been given opportunity for feedback; the feedback has been considered by developers.*

Usability (4b)

4b1: Improvement: *Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated.*

4b2: Benefits outweigh the harms: *The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).*

Criteria #3-4: Feasibility and Usability and Use

New measures	Maintenance measures
Feasibility	
• Measure feasible, including eMeasure feasibility assessment	NO DIFFERENCE: Implementation issues may be more prominent
Usability and Use	
• Use: used in accountability applications and public reporting	**INCREASED EMPHASIS**: Much greater focus on measure use and usefulness, including both impact and unintended consequences
• Usability: impact and unintended consequences	

Criterion #5: Related or Competing Measures (page 51-52)

If a measure meets the four criteria and there are endorsed/new related measures (same measure focus or same target population) or competing measures (both the same measure focus and same target population), the measures are compared to address harmonization and/or selection of the best measure.

- 5a. The measure specifications are harmonized with related measures **OR** the differences in specifications are justified.
- 5b. The measure is superior to competing measures (e.g., is a more valid or efficient way to measure) **OR** multiple measures are justified.

Updated guidance for measures that use ICD-10 coding: Fall 2017 and 2018

- Gap can be based on literature and/or data based on ICD-9 or ICD-10 coding
- Submit updated ICD-10 reliability testing if available; if not, testing based on ICD-9 coding will suffice
- Submit updated validity testing
  - *Submit updated empirical validity testing on the ICD-10 specified measure, if available*
  - *OR face validity of the ICD-10 coding scheme plus face validity of the measure score as an indicator of quality*
  - *OR face validity of the ICD-10 coding scheme plus score-level empirical validity testing based on ICD-9 coding*
  - *OR face validity of the ICD-10 coding scheme plus data element level validity testing based on ICD-9 coding, with face validity of the measure score as an indicator of quality due at annual update*

eMeasures

- "Legacy" eMeasures
  - *Beginning September 30, 2017 all respecified measure submissions for use in federal programs will be required to the same evaluation criteria as respecified measures – the "BONNIE testing only" option will no longer meet endorsement criteria*

- For all eMeasures: Reliance on data from structured data fields is expected; otherwise, unstructured data must be shown to be both reliable and valid

Social Risk Factor Initiative 2.0

- NQF Board approved a new 3-year initiative, where NQF will continue to allow the inclusion of social risk factors in outcome measures.

Through the continuation of the SDS Trial, NQF will:

- Identify preferred methodologies to link the conceptual basis for adjustment with the analyses to support it
- Develop guidance for measure developers
- Explore alternative data sources and provide guidance to the field on how to obtain and use advanced social risk factors data
- Evaluate risk models for appropriate social and clinical factors
- Explore the impact of social risk adjustment on reimbursement and access to care

Implement Social Risk Factor Initiative 2.0

As part of the continuation of the SDS Trial, NQF will:

- Continue to consider if an outcome measure includes the appropriate social and clinical factors in its risk model
- Convene the new Scientific Methods Panel and Disparities Standing Committee to provide guidance on the methodological questions that arose during the initial trial period
  - *SMP role: review validity and provide guidance to the Standing Committee reviewing the measure*
  - *Standing Committee role: make endorsement recommendation*
  - *DSC role: provide oversight and guidance on disparities*

Evaluation Process

- **Preliminary analysis (PA)**: To assist the Committee evaluation of each measure against the criteria, NQF staff and Methods Panel (if applicable) will prepare a PA of the measure submission and offer preliminary ratings for each criterion.
  - *The PA will be used as a starting point for the Committee discussion and evaluation*
  - *Methods Panel will complete review of Scientific Acceptability criterion for complex measures*
- **Individual evaluation**: Each Committee member conduct an in-depth evaluation on all measures
  - *Each Committee member will be assigned a subset of measures for which they will serve as lead discussant in the evaluation meeting.*

Evaluation Process

- **Measure evaluation and recommendations at the in-person/web meeting**: The entire Committee will discuss and rate each measure against the evaluation criteria and make recommendations for endorsement.
- **Staff will prepare a draft report** detailing the Committee's discussion and recommendations
  - *This report will be released for a 30-day public and member comment period*
- **Post-comment call**: The Committee will re-convene for a post-comment call to discuss comments submitted
- **Final endorsement decision by the CSAC**
- **Appeals** (if any)

Questions?

SharePoint Overview

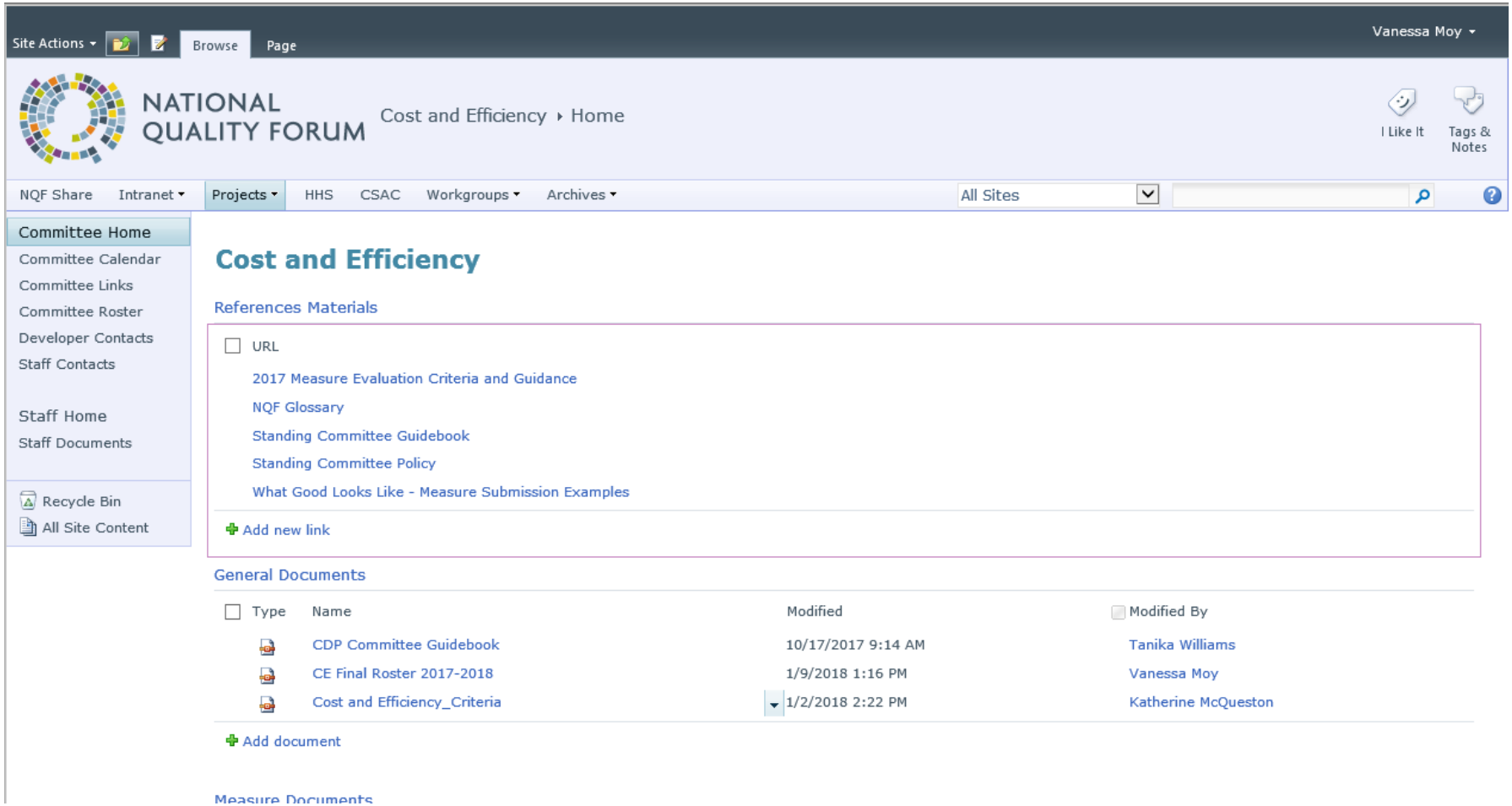
SharePoint Overview

http://share.qualityforum.org/Projects/costEff/SitePages/Home.aspx

- Accessing SharePoint
- Standing Committee Policy
- Standing Committee Guidebook
- Measure Document Sets
- Meeting and Call Documents
- Committee Roster and Biographies
- Calendar of Meetings

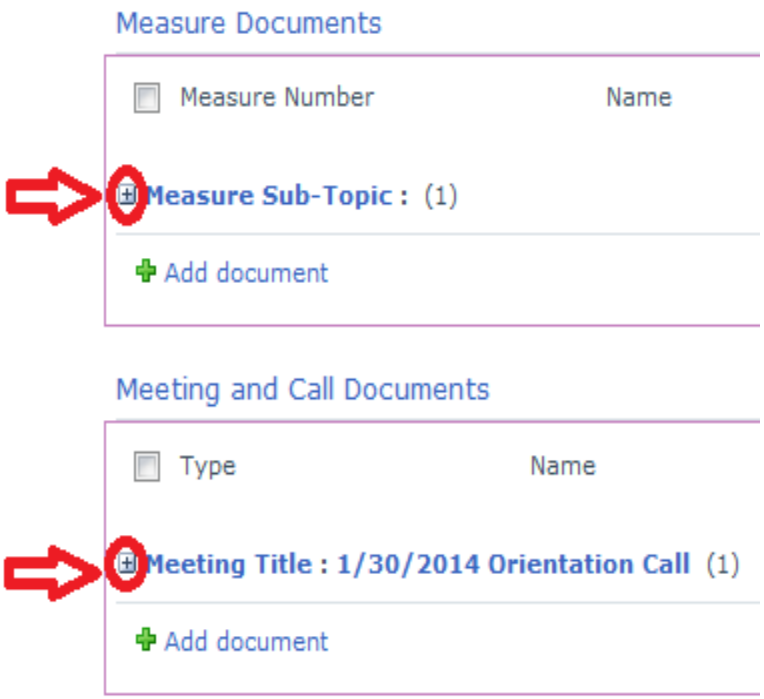
SharePoint Overview

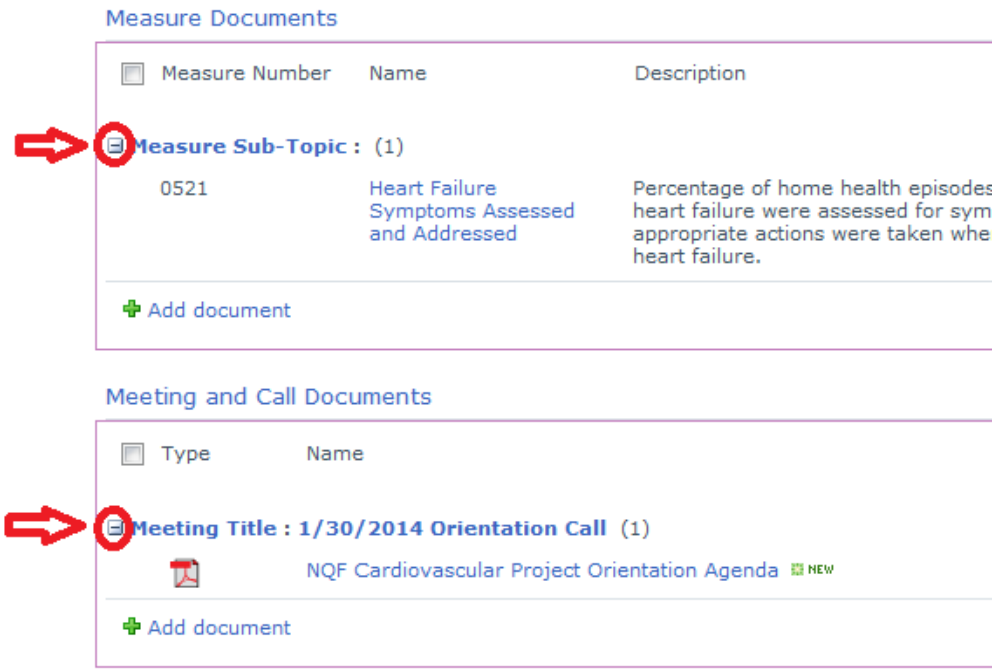
- **Screen shot of homepage:**



SharePoint Overview

- Please keep in mind:
- + and – signs :





Measure Worksheet and Measure Information

- Measure Worksheet
  - *Preliminary analysis, including eMeasure Technical Review if needed, and preliminary ratings*
  - *Member and Public comments*
  - *Information submitted by the developer*
    - » Evidence and testing attachments
    - » Spreadsheets
    - » Additional documents

Next Steps

Next Steps

*All times ET

Cycle 2

Meeting	Date/Time
Committee Measure Evaluation Web Meeting	Friday, June 29, 1:30-3:30 PM
Committee Post-Meeting Web Meeting	Thursday, July 12, 1:30-3:30 PM
Committee Post-Comment Web Meeting	Wednesday, September 12, 1:30-3:30 PM

Project Contact Info

- Email: efficiency@qualityforum.org
- NQF Phone: 202-783-1300
- Project page: https://www.qualityforum.org/Cost_and_Efficiency.aspx
- SharePoint site: http://share.qualityforum.org/Projects/costEff/SitePages/Home.aspx

Questions?


THANK YOU