Measure Developers' Workshop

November 14, 2012

NATIONAL QUALITY FORUM

Objectives for the Workshop

- Inform measure developers of NQF processes.
- Obtain feedback from developers on the methods employed to execute their work.
- Use feedback obtained to consider ways to improve existing NQF processes.
- Identify potential collaboration opportunities with and amongst measure developers.

Agenda: Day-1

- Introductions
- Overview Session
- Update on Two-Stage Process
- Break-out Sessions
- Report Back Session

Overview Session

- NQF ***Performance Measures Staff*** will give presentations on the following topic areas:
  - NQF Measure Evaluation Criteria
  - New Guidance on Usability and Use
  - Measure Disparities

Measure Evaluation Overview

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March 19, 2012

Lindsey Tighe, MS
Project Manager

Types of Performance Measures

- Quality
  - Structure
  - Process
  - Intermediate clinical outcome
  - Outcome
    - Use of services (used as proxy for outcome, cost)
- Resource use/cost
- Efficiency (combination of quality and resource use)
- Composite (combination of two or more individual measures in a single measure that results in a single score)

Evaluation Criteria

- Subcriteria delineate how to demonstrate that the major criteria are met
  - How do you know a measure is important, scientifically acceptable, etc.?
- Criteria parallel best practices for measure development
  - For example, begin with identifying what is important to measure, and later what is feasible
- Most criteria/subcriteria involve a matter of degree rather than all-or-nothing determination
  - Requires both evidence and expert judgment

Rating Scale

Rating	Definition
High	Based on the information submitted, there is high confidence (or certainty) that the criterion is met
Moderate	Based on the information submitted, there is moderate confidence (or certainty) that the criterion is met
Low	Based on the information submitted, there is low confidence (or certainty) that the criterion is met
Insufficient	There is insufficient information submitted to evaluate whether the criterion is met (e.g., blank, incomplete, or not relevant, responsive, or specific to the particular question)

Criterion # 1: Impact, Opportunity, Evidence– Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in health care quality and improving health outcomes for a specific high-impact aspect of healthcare where there is variation in or overall less-than-optimal performance.

- Must pass criterion
- Must pass all three subcriteria
  - 1a. High impact
  - 1b. Performance gap/opportunity for improvement**
    - Including disparities
  - 1c. Evidence supports measure focus

** Measures being reviewed for endorsement maintenance may qualify for reserve status if they address an important aspect of quality but fail to demonstrate a gap in performance and certain other criteria are met. Such measures should be rated on all evaluation criteria

Criterion # 2: Reliability and Validity – Scientific Acceptability of Measure Properties

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

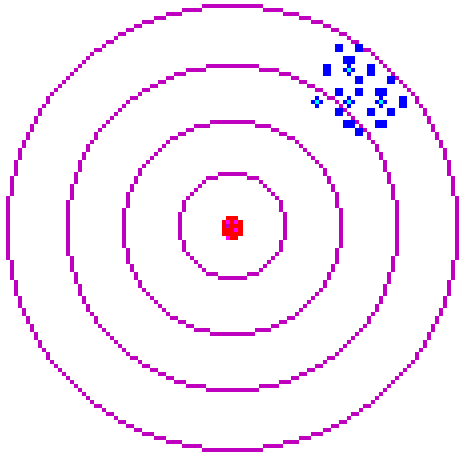
2a. **Reliability (must-pass)**
- 2a1. Precise specifications including exclusions (previously 2d)
- 2a2. Reliability testing—data elements or measure score

2b. **Validity (must-pass)**
- 2b1. Specifications consistent with evidence
- 2b2. Validity testing—data elements or measure score
- 2b3. Justification of exclusions—relates to evidence
- 2b4. Risk adjustment
- 2b5. Identification of differences in performance
- 2b6. Comparability of data sources/methods

2c. Stratification for disparities – *disparities now just addressed in 1b*

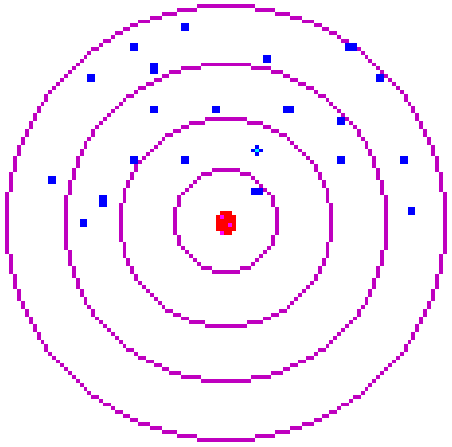
Reliability and Validity

Assume the center of the target is the true score…



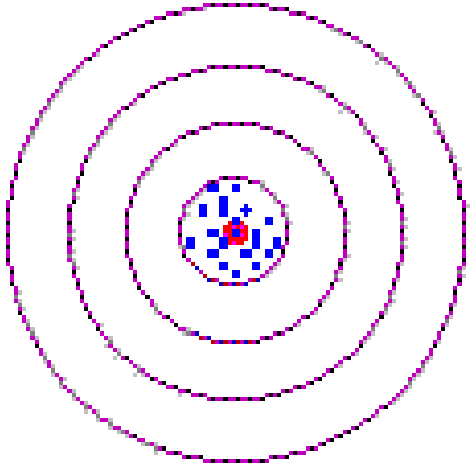
Reliable Not Valid

Consistent, but wrong



Neither Reliable Nor Valid

Inconsistent & wrong



Both Reliable And Valid

Consistent & correct

Measure Testing

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.

--Measure Testing Guidance Report

Evaluation of Testing

- Was the measure tested at the level of the data elements and/or the measure score?
  - » High rating only if tested at both data element and measure score
  - » Moderate – highest rating possible if only tested either data elements or measure score
  - » Face validity acceptable only if systematically assessed

- Was an appropriate method used?
  - Consider level (data or score), data source, type of measure, topic, potential sources of error, conceptual relationships, feasibility
- Was the scope of testing adequate?
  - If sample, consider number of entities, number of patients, representativeness
- Were the results within acceptable norms?

Criterion # 3: Usability*

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making.

- 3a. Meaningful, understandable, and useful for public reporting
  - Is it in use for public reporting or an accountability application and if not, what is plan/progress?
  - Is the rationale for use in accountability credible?

- 3b. Meaningful, understandable, and useful for quality improvement
  - Is it in use for improvement, and if not what is the plan/progress?
  - Is the rationale for use in QI credible?

** Updated criteria will be implemented in late 2012*

Criterion # 4: Feasibility

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

- 4a. Clinical data generated and used during care process
  - Blood pressure, lab value vs. survey or observation
- 4b. Electronic sources
  - EHR, claims vs. abstracted and entered into database/registry
  - Is there a credible, near-term path to electronic collection?
- 4c. Susceptibility to inaccuracies/unintended consequences identified
  - Ability to audit and detect?
- 4d. Data collection strategy can be implemented
  - Is it already in operational use or testing indicated ready for operational use?

5. Comparison to Related or Competing Measures

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.

Measure Evaluation Guidance

- Reports on guidance for measure evaluation:
  - Evidence for the Focus of Measurement and Importance to Measure and Report
  - Measure Testing and Scientific Acceptability of Measure Properties
  - Measure Harmonization
- Updated Measure Evaluation Criteria
- Specific rating scales for evidence (1c), reliability (2a), and validity (2b)
- Decision tables for Importance to Measure and Report and Scientific Acceptability of Measure Properties
- Revised Measure Submission Form
  - Most changes related to guidance on evidence (1c)
  - Some changes related to taxonomy (primarily response options, e.g., setting)
  - Some clarification in wording/instructions

Usability and Use: New Guidance Information

Measure Developer Workshop

November 14-15, 2012

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Current Status

- Usability Task Force Report was approved by the Board on February 24, 2012

- Effective for measures submitted last quarter of 2012

Key Concepts/Decisions

- The goal of NQF-endorsed measures is to facilitate high-quality, efficient healthcare
- *Usability* is a hypothetical characteristic that can be evaluated at the time of initial endorsement
- Over time, observed *use* and progress toward achieving the goal of measurement – high-quality, efficient healthcare – can be evaluated
- NQF-endorsed measures will be used in a variety of accountability applications (not just public reporting)

Key Concepts/Decisions (cont'd)

- Some degree of transparency is a characteristic of all accountability applications; public reporting is still an important goal
- Implementation in accountability applications and demonstrated improvement - require time and are subject to many external factors
  - Expectations for use of NQF-endorsed measures should be explicit
  - Endorsement decision requires judgment of multiple factors

Key Concepts/Decisions

- Usability is influenced by all the other criteria – *Importance to Measure and Report*, *Scientific Acceptability of Measure Properties*, *Feasibility* – and should be evaluated last
- Lack of use may be a signal for potential problems with other criteria, particularly opportunity for improvement, evidence, reliability, validity, feasibility
- Ultimately endorsement recommendations requires judgment after weighing the information (e.g., reasons for nonuse, timeframe, benefits if it could be implemented)

Issues Related to Evaluating Usability

- Unintended consequences should be evaluated under Usability (not Feasibility)
- Usability should not encompass understanding and interpretability, which is context specific (i.e., related to purpose and audience) and is correctable
- Usability should not encompass reporting presentations, data displays, or methodologies for classification
- Recommend that NQF explore the pros and cons of including reporting guidance in its measure review and endorsement process

Evaluation Criteria

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and performance improvement[18] to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency[19]

Performance results are used in at least one accountability application[1] within three years after initial endorsement and are publicly reported[19] within six years after initial endorsement (or the data on performance results are available).[20] If not in use at the time of initial endorsement, then a credible plan[21] for implementation within the specified timeframes is provided.

AND

Evaluation Criteria (cont'd)

4b. Improvement[22]

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated.[22] If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

AND

4c. 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).

Accompanying Notes

1. Accountability applications are the use of performance results about identifiable, accountable entities to make judgments and decisions as a consequence of performance, such as reward, recognition, punishment, payment, or selection (e.g., public reporting, accreditation, licensure, professional certification, health information technology incentives, performance-based payment, network inclusion/exclusion). **Selection** is the use of performance results to make or affirm choices regarding providers of healthcare or health plans.

18. An important outcome that may not have an identified improvement strategy still can be useful for informing quality improvement by identifying the need for and stimulating new approaches to improvement.

Accompanying Notes (cont'd)

19. Transparency is the extent to which performance results about identifiable, accountable entities are *disclosed and available* outside of the organizations or practices whose performance is measured. Maximal transparency is achieved with **public reporting** defined as making comparative performance results about identifiable, accountable entities freely available (or at nominal cost) to the public at large (generally on a public website). *At a minimum, the data on performance results about identifiable, accountable entities are available to the public (e.g., unformatted database)*. The capability to verify the performance results adds substantially to transparency.

20. This guidance is not intended to be construed as favoring measures developed by organizations that are able to implement their own measures (such as government agencies or accrediting organizations) over equally strong measures developed by organizations that may not be able to do so (such as researchers, consultants, or academics). Accordingly, measure developers may request a longer timeframe with appropriate explanation and justification.

Accompanying Notes (Continued)

21. Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.

22. Demonstrated progress toward achieving the goal of high-quality, efficient healthcare includes evidence of improved performance and/or increased numbers of individuals receiving high-quality healthcare. Exceptions may be considered with appropriate explanation and justification.

Usability and Use: New Submission Form Items

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Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Current and Planned Use (check all the current and planned uses; for any current uses that are checked, provide a URL for the specific program)

Current and Planned Use (Continued)

	Planned	Current	URL
Public Reporting			
Payment Program			
Public Health/Disease Surveillance			
Professional Certification or Recognition Program			
Regulatory and Accreditation Programs			
Quality Improvement with Benchmarking (external benchmarking to multiple organizations)			
Quality Improvement (Internal to the specific organization)			
Not in use			
Use unknown			

Current Use

For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

Accountability and Transparency

If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? *(e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or block implementation?)*

If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. *(Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)*

Improvement

Provide data that demonstrate improvement in performance and/or health. (Not required for initial endorsement unless available.)

Include:

- Source of data
- Geographic area and number and percentage of accountable entities and patients included
- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)

Improvement (Continued)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Unintended Consequences

Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

Questions?

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Measure Disparities

November 14, 2012

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Methodological Approaches for Healthcare Disparities - Commissioned Paper

- Data Collection: Building the Foundation
- Disparities Measures and Indicators: What to Measure?
- Methodological Approaches to Disparities Measurement: How to Measure/Monitor?
  - Reference Points, Absolute vs. Relative Disparities, Paired vs. Summary Statistics, Normative Judgments, Interaction Effects, Risk Adjustment and Stratification, Sample Size Considerations
- Priorities and Recommendations for Quality Improvement and Public Reporting

Identifying Disparities-Sensitive Measures

- Using guidance from commissioned paper, Steering Committee established protocol for identifying measures as disparities-sensitive
  - NQF-endorsed portfolio of measures were screened and tagged as disparities-sensitive (measures should be routinely stratified and reported by race/ethnicity and language)
- Screening protocol includes a hierarchical approach and scoring system, with **emphasis on prevalence** of the condition among the minority population, the **disparities quality gap**, the **impact** of the condition and whether a **measure was mapped to a communication-sensitive practice** for care coordination or cultural competency.

Disparities-Sensitive Measures Criteria

- Prevalence
- Impact
- Disparities Quality Gap
- Additional criteria:
  - Communication-sensitive services

Disparities-Sensitive Measure Criteria – Prevalence

Prevalence – How prevalent is the condition among the minority population?

Disparities Indicator
Measures related to the following conditions: Cancer, Diabetes, Heart Disease (including Hypertension), HIV/AIDS, Immunizations, Infant Mortality, Stroke, Tobacco Use, Oral Care. Cross-cutting areas (e.g., safety, care coordination, functional status, palliative care, pain management, child health)
High Impact conditions, including prioritized list of top 20 Medicare conditions; amended to include substance abuse, obesity, and End Stage Renal Disease
All other measures

Disparities-Sensitive Measures Criteria: Impact

Impact – The influence a condition or topic has financially, publically, and on the community at large.

Disparities Indicator for Impact
Measure addresses the National Quality Strategy priority areas or goals
Measure demonstrates high impact aspect of healthcare (1a) (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use, severity of illness, and patient/societal consequences of poor quality) as demonstrated on the measure submission/evaluation form

Disparities-Sensitive Measures Criteria: Disparities Quality Gap

Disparities Quality Gap –

How large is the gap in the quality of care between the disadvantaged population and the group with the highest quality for that measure?

Disparities-Sensitive Measure Criteria: Additional Criteria

Communication-sensitive Services – Disparities are more likely to occur when there are challenges to communication across language and cultures.

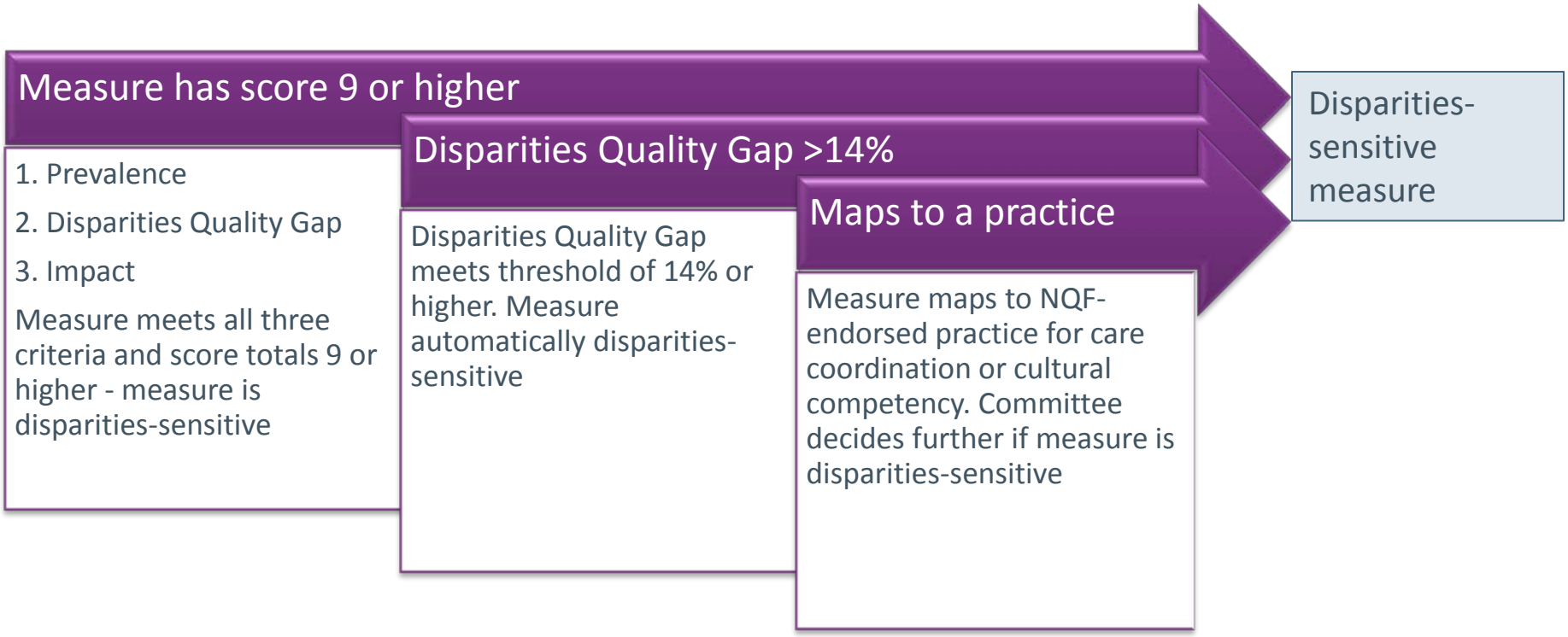
Disparities Indicator
Measure can be mapped to NQF-endorsed preferred practices for cultural competency. Specifically, those practices addressing patient-provider communication.
Measure can be mapped to NQF-endorsed preferred practice for care coordination. Specifically, those practices addressing communication

Illustrative Example of Protocol

Controlling High Blood Pressure (NQF#0018): The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. (Steward: National Committee for Quality Assurance)

Protocol Indicator	Measure rationales
Prevalence	Measure meets one of the conditions under prevalence – Heart Disease
Quality Gap	A quality gap of 13% was provided by the measure developer
Impact	Measure can be mapped to at least one of the NQS priority areas or goals
Communication-sensitive services	Measure does not map to NQF-endorsed practices addressing communication sensitive services

Selecting Disparities-Sensitive Measures



Prospective Approach: Disparities-Sensitive Measures

- Revise the measure submission form to provide more clarity for disparities data.
- Work with measure developers on the disparities data required for the measure submission form
  - Retrospective review: more than 75% of measure submission forms reviewed did not have sufficient information
- Routinely identify disparities-sensitive measures within endorsement maintenance projects going forward
  - Disparities quality gap threshold to be reviewed annually and adjusted as necessary

Disparities-Sensitive Measures: Implications

- The identification of disparities-sensitive measures is an important step toward routine assessment of disparities.
- Initial set of disparities-sensitive measures will be tagged as "disparities-sensitive" in the QPS
- This initial set of disparities-sensitive measures, the prospective approach for all measures undergoing endorsement maintenance, and the use of disparities-sensitive measures for accountability will continue to evolve as quality and disparities measurement evolve.
- Consider impact of stratified measures on accountability and quality improvement/unintended consequences.

Two-Stage Consensus Development Process & Pilot Project

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Measure Developer Workshop
November 14, 2012

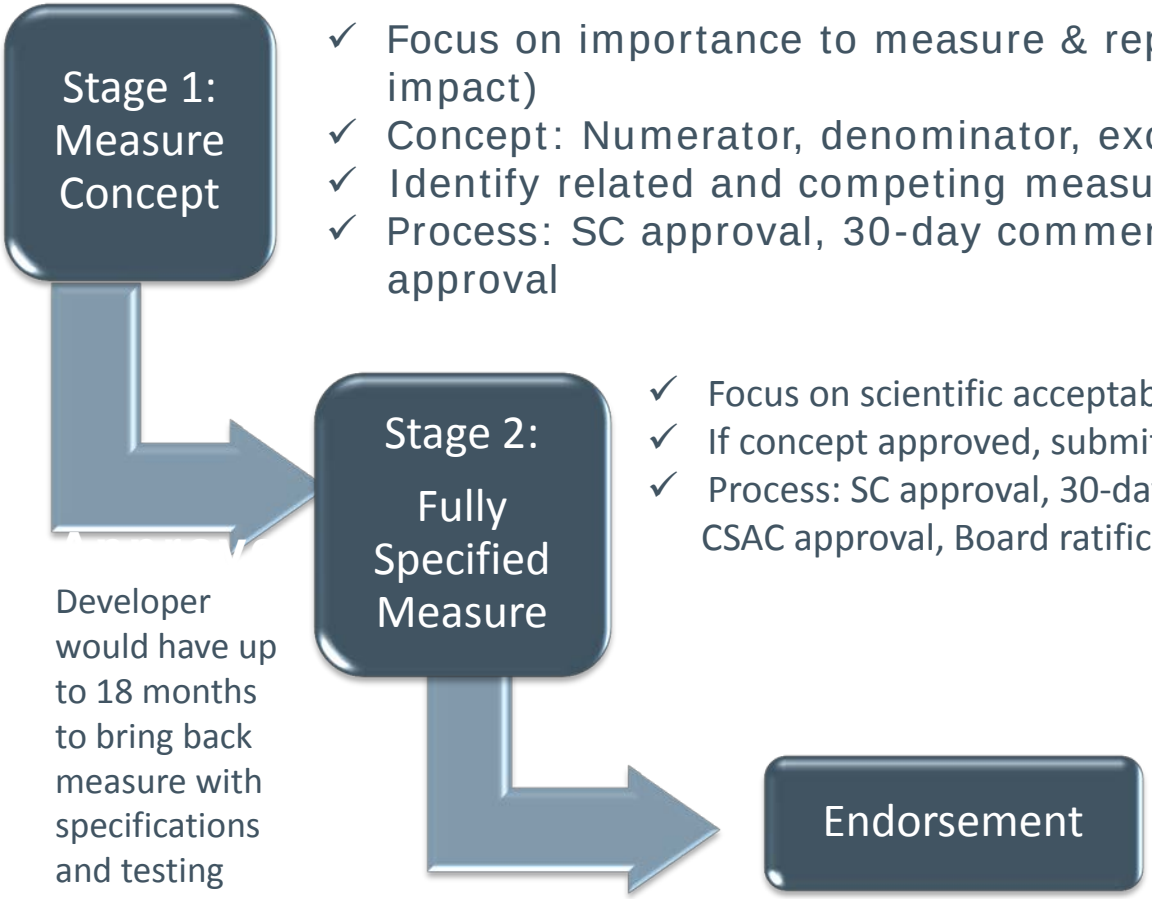
Agenda

I. Overview of the two-stage process & pilot project
II. Implementation of new pilot steps/resources/tools
III. Challenges
IV. NQF next steps

The proposed two-stage CDP

- Goals
  - Identify measure harmonization opportunities earlier in the process
  - Provide early input on measure concept *before the* measure is fully developed and tested
    - » Savings in costs and resources
    - » Expert input on measure development
    - » ¼ of the CDP process is complete with vetting against the Importance criterion
  - Improve quality of measure submissions
  - More frequent endorsement cycles

Proposed Two-Stage Endorsement Process



- ✓ Focus on importance to measure & report (evidence, gap, impact)
- ✓ Concept: Numerator, denominator, exclusion statements
- ✓ Identify related and competing measures
- ✓ Process: SC approval, 30-day comment period, CSAC & Board approval

- ✓ Focus on scientific acceptability, feasibility, usability
- ✓ If concept approved, submit specified & tested measure
- ✓ Process: SC approval, 30-day comment, 2 week vote, CSAC approval, Board ratification

Developer would have up to 18 months to bring back measure with specifications and testing

Pilot Process

- Developers will be required to seek technical assistance prior to submitting measures to Stage 2
- 30 days prior to the submission deadline

- 2 week member voting period during Stage 2 only

- Final approval will include checklist of items that must be addressed before submitting for stage 2 review including harmonization and competing measures issues

Measure Submission

- Developer must demonstrate that checklist for Stage 2 review has been met

Steering Committee Review

- Meetings take place on a set schedule per topic area
- Members will be able to submit comments for Committee consideration

Draft Report

- Recommendations from committee will be released for comment

Public Comment

- CSAC/Board provide early input

Member Voting

CSAC / Board Approval

- Measures to flow through approval process by CSAC/ Board
- Measures are endorsed and appeals are opened

Stage 1 Evaluation: Measure Concept

- Includes:
  - Numerator statement
  - Denominator statement
  - Exclusions under consideration
  - Risk adjustment variables under consideration
  - Preliminary specifications (not necessarily coding)
  - Planned use
  - Mapping to taxonomy (i.e., proposed levels of analysis, data source, settings of care, topic area)

What will be evaluated in Stage 2?

- Measure with specifications and testing results
- Data on remaining three criteria:
  - Scientific Acceptability
  - Usability and Use
  - Feasibility
- Recommendations for measure endorsement

Project Overview

- Gastrointestinal (GI) and Genitourinary (GU) concepts
- 18 concepts submitted
  - 10 GU
  - 8 GI
  - 6 maintenance

- 8 Developer organizations
  - NCQA
  - AMA-PCPI
  - ActiveHealth
  - AGA
  - AUA
  - AUGS
  - AHRQ
  - Quality Quest for Health of Illinois

Committee & CSAC Recommendations

	Submitted	Recommended by Steering Committee	Recommended by CSAC	Anticipated for submission for Stage 2 review in 2013
New Concepts	11	7	5	0
Maintenance Measures	6	6	6	6
New fully specified and tested measures	1	1	1	1
Total	**18**	**14**	**12**	**7**

Project Activities to Date

- Implementation of new pilot steps/resources/tools
  - Steering Committee Guidebook
  - ***NQF Technical Review***
  - ***Developer Guidebook***
  - Pre-meeting member commenting period
  - ***Concept Submission Form*** / Evidence Attachment
  - Developer Checklist
- Steering Committee (August 27-28)
  - 14 out of 18 concepts were recommended for approval
  - Committee feedback session
- Commenting
  - Member and public comment period closed: 10/25/2012
  - Steering Committee call to discuss comments: 10/31/2012
- CSAC
  - 12 out of 14 recommended by the Steering Committee were advanced by CSAC: 11/7/2012
- Pilot Evaluation- Ongoing

Proposed Two-stage CDP Evaluation Plan

- Piloted through GI/GU project; currently focused on results for Stage 1
- Experience predicated on multiple stakeholders perspectives of process (CSAC, Committee, membership, developers, NQF staff) and reports
- Identifies redesign components (i.e., *technical review process*) and several desired outcomes (i.e., *technical review will ensure submissions are complete*)
- Evaluation focus (i.e., *determine whether review process improves quality of concept submissions, can concepts be evaluated separately*) maps to evaluation metrics and data sources
  - Evaluation metrics (i.e., *developer, Committee, NQF staff perceptions about the technical review process and # of submissions with missing information*)
  - Data sources (surveys, structured discussions, measure tracking log, budget, project timeline)

Technical Review

Purpose

1. Provide developers with early input on quality of submissions related to completeness and responsiveness
2. Improve the quality of submission forms for Steering Committee review
3. Provide dedicated staff to provide technical review input to improve consistency of staff review and quality control

Developer Guidebook

Purpose

1. Provide a written resource for developers to reference for guidance on the submission process and the consensus development process
2. Provide concrete examples of appropriate and responsive submission form questions for guidance during the submission process ("what good looks like")

Qualitative analysis: Technical review process

NQF Technical Review Team & CDP Team

Assessed overall experience, perceptions of the value of the process, quality of submitted measures, and assessment of resources

- Administered via individual interviews and structured group discussion
  - Sense that technical review was integral part of 2-stage process
  - Developer receptiveness of feedback received varied based on experience with NQF process
  - Unsure of overall value of process and impact on measure submissions
  - Adequate staffing, but difficult managing compressed timeline
  - Submissions improved slightly following technical review

Qualitative analysis: Technical review process (cont.)

Measure developers

- Administered via online survey (33% response rate, from 8 organizations)
  - Assessed receptiveness of feedback received; utility of resources; and value of process
  - Developer guidebook (30% valuable, 60%-somewhat, 10%-not valuable)
    - **"What good looks like" (50%-valuable, 20%-somewhat, 10%-not valuable)**
  - Feedback and overall value (40%-valuable, 50%-somewhat, 10% not valuable)
  - **Use TA if offered in future? (80% yes, 10%-maybe, 10%-no)**

Concept Submission Form Items

- Includes:
  - Numerator statement
  - Denominator statement
  - Exclusions under consideration
  - Risk adjustment variables under consideration
  - Preliminary specifications (not necessarily coding)
  - Planned use
  - Mapping to taxonomy (i.e., proposed levels of analysis, data source, settings of care, topic area)
  - Information to demonstrate importance criterion
    - High Impact
    - Evidence
    - Performance Gap
  - Assessment of related and competing measures

Stage 1 Challenges

(Identified by NQF Staff)

- Evidence review
  - Often insufficient information was presented by developers
- Implementing the evaluation of Importance criterion only
  - Difficult to isolate evaluation of importance to measure and report and validity of measure specifications
- Addressing harmonization of concepts
- Incorporating Committee feedback on submitted concepts
  - New concepts vs. maintenance and fully specified and tested measures
  - Impact on approval
  - Transition time between stages

Next steps

- Continue to improve and develop tools and resources to support the process
  - Developer Guidebook
  - Steering Committee Guidebook
- Develop stage 2 evaluation plan
- Administer online membership survey of stage 1 (early December 2012)
- Determine what changes should be recommended to the CDP related to the review of concepts (December 2012-January 2012)
  - Assess pilot evaluation feedback in the context of consensus task force input and focus group findings

GI & GU Pilot Timeline –Stage 1

Concept Evaluation-Stage 1		
Task	**Start**	**Finish**
Open Call for Concepts/Measures		6/4/12
REQUIRED Technical assistance deadline		6/25/12
Concept Submission deadline		7/16/12
Member comment period opens		8/1/12
SC In Person Meeting #1 (concepts only)	8/27/12	8/28/12
NQF Member and Public Comment (30 days)	9/24/12	10/25/12
CSAC Review	11/7/12	11/16/12
NQF Board Approval	11/19/12	11/30/12

GI & GU Pilot Timeline –Stage 2

Measure Evaluation- Stage 2		
Task	**Start**	**Finish**
Measure submission forms open for approved concepts		11/19/12
REQUIRED Technical assistance deadline		12/7/12
Measure submission deadline		1/4/13
Member comment period opens		1/22/13
SC In Person Meeting #2 (measure review)	2/6/13	2/7/13
NQF Member and Public Comment	3/4/13	4/2/13
NQF Member Vote	4/25/13	5/8/13
CSAC Review	5/9/13	5/24/13
NQF Board Approval	5/27/13	6/3/13
Appeals	6/4/13	7/2/13
Project Evaluation/wrap up	7/3/13	7/17/13

Breakout Sessions

November 14, 2012

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Break-out Session Logistics

- The break-out sessions will run for and hour at their designated locations.
- Participants can attend two of the three break-out sessions (based on preference).
  - Sessions start at 2:00pm
- The participants are to designate 1 or 2 people to serve as reporters for the group.
  - Break-out facilitators will provide instructions on what information to collect.
- Group will reconvene in large conference room at 4:15pm.