NATIONAL QUALITY FORUM

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Priority Setting for Health Care Performance Measurement: Addressing Performance Measure Gaps in Priority Areas

Health Workforce

April 15-16, 2014

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NATIONAL QUALITY FORUM

Agenda

Priority Setting for Health Care Performance Measurement: Addressing Performance Measure Gaps in Priority Areas

Health Workforce Committee Meeting

April 15-16, 2014

NQF Conference Center at 1030 15th Street NW, 9th Floor, Washington, DC

Remote Participation Instructions:

Streaming Audio Online

- Direct your web browser to: http://nqf.commpartners.com
- Under "Enter a Meeting" type the meeting number for Day 1: **859466** or for Day 2: **441034**
- In the "Display Name" field, type your first and last name and click "Enter Meeting"

Teleconference

- Dial **(888) 802-7237** for committee members and **(877) 303-9138** for public audience
- Use conference ID code for Day 1: **9027164** and use conference ID code for Day 2: **9036677** to access the audio platform.

Meeting Objectives:

- Build shared understanding of environmental drivers of workforce measurement activities
- Refine domains and sub-domains of measurement for the deployment of the health workforce, developing potential measure concepts in key areas
- Prioritize opportunities for health workforce measurement to inform HHS

Day 1: Tuesday, April 15, 2014

8:30 am **Breakfast**

9:00 am **Welcome and Review of Meeting and Project Objectives**
Melissa Gerdes and Ann Lefebvre , Committee Co-Chairs

9:15 am **HHS Opening Remarks**
Ann Page, Office of the Assistant Secretary for Planning and Evaluation, HHS
Girma Alemu, Office of Planning, Analysis, and Evaluation, HRSA

9:30 am **Review Project Progress to Date**

Angela Franklin, Senior Director, NQF

Allison Ludwig, Senior Project Manager, NQF

- Review of project elements: Definitions, conceptual framework and environmental scan, and web meeting themes
- Committee affirmation of elements

9:50 am **Connecting NQF's Efforts to Prioritize Measure Gaps**

Wendy Prins, Senior Director, NQF

- Prioritizing Measure Gaps
- MAP Person- and Family-Centered Care Task Force
- Committee discussion of other related efforts

10:10 am **Environmental Context and Measure Uses**

Edward Salsberg, Research Faculty, George Washington University

- Environmental context
- Feasibility and Potential Uses of Measures
- Committee discussion

10:45 am **Break**

11:00 am **NQF Endorsement Criteria**

Karen Pace, Senior Director, NQF

11:30 am **Considerations for Performance Measurement**

Melissa Gerdes

Ann Lefebvre

- Considerations :
  - Structure, process and outcome measures, including patient-reported outcomes
    - How can measures of the workforce promote improvements in deployment?
    - What measures are important to stakeholders?
    - How can measures promote improvements in care delivered by the workforce?
  - Level of analysis
    - What is the most useful level of analysis – national, state, community, organization (employer, educational institution)?
    - What level(s) of analysis are likely to have the greatest impact in promoting improvements, national, state, community, organization (employer, educational institution)?
  - Data sources
    - What are the pros and cons of the various data sources?
    - What are short-term considerations versus longer-term possibilities?
  - Measure costs and burden
    - What are the cost/burden considerations for measurement?

12:30 pm **Lunch**

1:00 pm **Opportunity for Public Comment**

1:05 pm **Evaluate Draft Domains and Sub-Domains for Health Workforce Measurement**
Melissa Gerdes and Ann Lefebvre
- Review homework results
- Committee discussion to refine domains and sub-domains for measurement

2:15 pm **Break**

2:30 pm **Small Group Work: Generating Measure Concepts**
Angela Franklin and Allison Ludwig
All Committee Members
- Overview and instructions
- Group Break Out: Groups to brainstorm to create potential measure concepts for each of the measurement sub-domains

3:45 pm **Report Out from Small Groups**
All Committee Members
- Share progress in creating potential measure concepts
- Discussion about additional potential concepts

4:30 pm **Opportunity for Public Comment**

4:45 pm **Summary of Day and Adjourn**
Melissa Gerdes and Ann Lefebvre

Day 2: Wednesday, April 16, 2014

8:30 am **Breakfast**

9:00 am **Welcome from NQF**
Christine Cassel, CEO, NQF

Review Previous Day's Themes
Melissa Gerdes and Ann Lefebvre

9:15 am **Priorities Round up and Top Recommendations**
Melissa Gerdes and Ann Lefebvre
All Committee Members

10:30 am **Opportunity for Public Comment**

10:45 am **Break**

11:00 am **Final Measure Gap Prioritization Exercise**
Melissa Gerdes and Ann Lefebvre
All Committee Members
- Committee dot voting/consensus on recommendations

12:30 pm **Lunch**

1:00 pm **Round-Robin Discussion of Themes and Future Development of Measures: Recommendations to HHS**
All Committee Members

1:45 pm **Opportunity for Public Comment**

1:50 pm **Wrap Up/Next Steps**
Melissa Gerdes and Ann Lefebvre

- Public comment period for draft report – June 23-July 14
- Public webinar on project findings – June 30, 3-5 pm EST
- Final Report due August 15, 2014

2:00 pm **Adjourn**

Prioritizing Measure Gaps - Health Workforce Committee Roster

CO-CHAIRS	
Ann Lefebvre, MSW, CPHQ	University of North Carolina at Chapel Hill
Melissa Gerdes, MD	Methodist Health System

COMMITTEE MEMBERS	
Evaline Alessandrini, MD, MSCE	Cincinnati Children's Hospital Medical Center
Howard Berliner, ScD	Service Employees International Union (SEIU)
Barbara Brandt, PhD	University of Minnesota
Amy Khan, MD, MPH	Saint Mary's Health Plan
Christine Kovner, PhD, RN, FAAN	New York University, College of Nursing
Peter Lee, MD, MPH, FACOEM	General Electric
Gail MacInnes, MSW	Paraprofessional Healthcare Institute (PHI)
Tami Mark, PhD, MBA	Truven Health Analytics
Jean Moore, BSN, MSN	State University of New York at Albany School of Public Health
Robert Moser, MD	Kansas Department of Health and Environment
Sunita Mutha, MD	University of California San Francisco
Robert Phillips, MD, MSPH	American Board of Family Medicine
William Pilkington, PhD	Cabarrus Health Alliance
Jon Schommer, PhD	University of Minnesota
John Snyder, MD, MS, MPH (FACP)	Health Resources and Services Administration (HRSA)
Julie Sochalski, PhD, RN	University of Pennsylvania School of Nursing
Charles vonGunten, MD, PhD	Ohio Health Kobacker House
Gregg Warshaw, MD, AGSF	University of Cincinnati College of Medicine
George Zangaro, PhD, RN	Health Resources and Services Administration (HRSA)
Andrew Zinkel, MD, FACEP	HealthPartners

DEPARTMENT OF HEALTH AND HUMAN SERVICES REPRESENTATIVES	
Cille Kennedy	Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Girma Alemu	Health Resources and Services Administration (HRSA)

Priority Setting for Health Care Performance Measurement: Addressing Performance Measure Gaps in Priority Areas

NATIONAL QUALITY FORUM

Health Workforce Committee Meeting

April 15-16, 2014

Welcome

Prioritizing Measure Gaps: Health Workforce Committee Meeting Objectives

- Build shared understanding of environmental drivers of workforce measurement activities
- Refine domains and sub-domains of measurement for the deployment of the health workforce, developing potential measure concepts in key areas
- Prioritize opportunities for health workforce measurement to inform HHS

Today's Agenda – Tuesday, April 15 – Part 1

9:00 Welcome and Review of Meeting and Project Objectives

9:15 HHS Opening Remarks

9:30 Review Project Progress to Date

9:50 Connecting NQF's Efforts to Prioritize Measure Gaps

10:10 Environmental Context and Measure Uses

10:40 NQF Endorsement Criteria

11:10 Considerations for Performance Measurement

12:25 Opportunity for Public Comment

12:30 Lunch

Today's Agenda – Tuesday, April 15 – Part 2

1:00 Evaluate Draft Domains and Sub-Domains for Health Workforce Measurement

2:15 Break

2:30 Small Group Work: Generating Measure Concepts

3:45 Report Out from Small Groups

4:30 Opportunity for Public Comment

4:45 Summary of Day and Adjourn

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George Zangaro, PhD, RN	Health Resources and Services Administration (HRSA)
Andrew Zinkel, MD, FACEP	HealthPartners

Team Introductions and Housekeeping Announcements

- NQF Staff
  - Angela Franklin, Senior Director
  - Allison Ludwig, Senior Project Manager
  - Laura Ibragimova, Project Analyst
  - Severa Chavez, Project Analyst (not present)
  - Wendy Prins, Senior Director (cross-task coordination)
- Announcements
  - Participation
  - Travel/Expense Reimbursement
  - Breaks

HHS Opening Remarks

Ann Page, Acting Director, Division of Health Care Quality and Outcome, Office of the Assistant Secretary for Planning and Evaluation, HHS

Girma Alemu, Subject Matter Task Lead, Office of Planning, Analysis, and Evaluation, HRSA

Review Project Progress to Date

Framework Definitions

Healthcare Workforce

- "All people engaged in actions whose primary intent is to enhance health" – WHO
  - The clinical, non-clinical and LTSS workforce will be considered

Care Coordination

- "Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care." – AHRQ Care Coordination Measures Atlas
  - The experience of care coordination from community and volunteer workforce perspectives will also be considered

Framework Definitions, continued

Primary Care

- "Primary Care is the provision of integrated, accessible health services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." – IOM

Health

- "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." – WHO

National Prevention Strategy

- Aim: "To guide our nation in the most effective and achievable means for improving health and well-being. The Strategy prioritizes prevention by integrating recommendations and actions across multiple settings to improve health and save lives."
- Vision: "Working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness."
- Goal: "Increase the number of Americans who are healthy at every stage of life."

Draft Conceptual Framework

Frameworks and Resources Considered

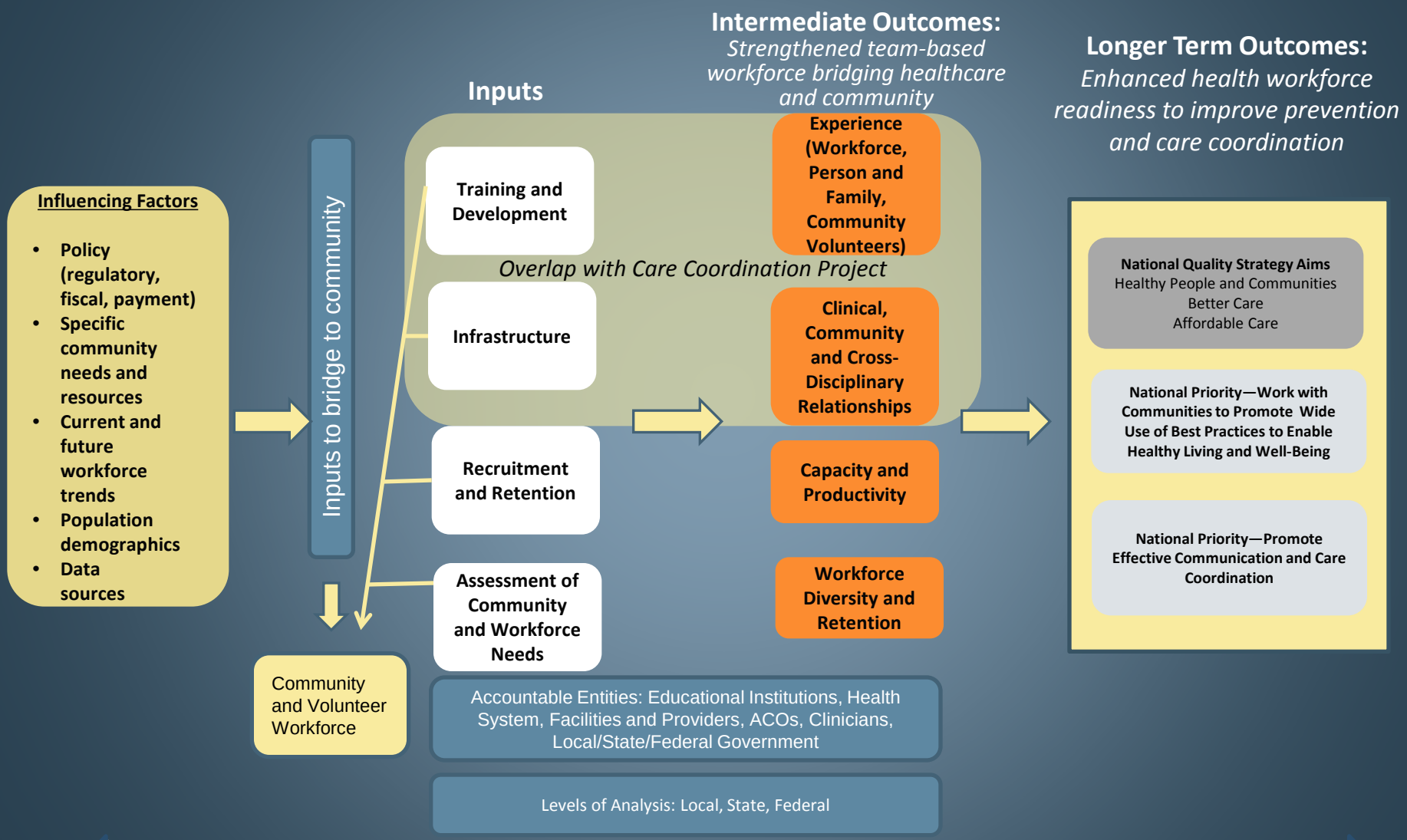
- AHRQ Care Coordination Measures Atlas
- AHRQ Clinical-Community Relationships Measures Atlas and Evaluation Roadmap
- Institute of Medicine - Health Professions Education: A Bridge to Quality
- NQF Multiple Chronic Conditions Measurement Framework
- HHS and Health Resources and Services Administration input

Development of Framework

- Overarching lens of assessing the community's needs and workforce in terms of prevention and care coordination (bottom of framework)
- Inputs and outputs captured from literature and reviewed frameworks
  - Domains stated were frequently mentioned
- Center of the model derived from the "IOM - Health Professions Education: A Bridge to Quality" (2003), which keeps focus on the person

Framework for Action: Effective and Efficient Workforce Development and Deployment to Improve Care Coordination and Prevention

(focus on the professional/paraprofessional workforce)



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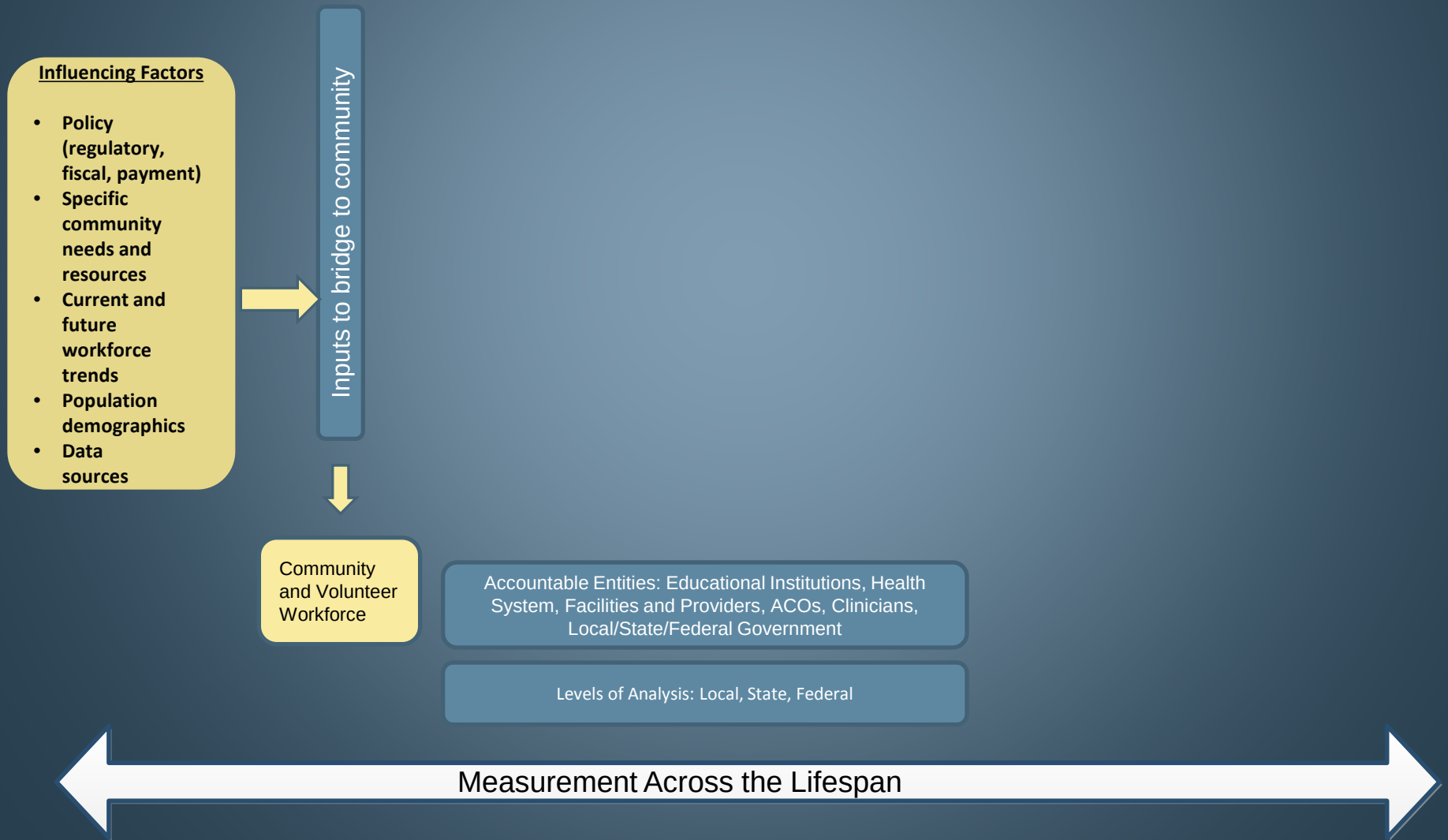
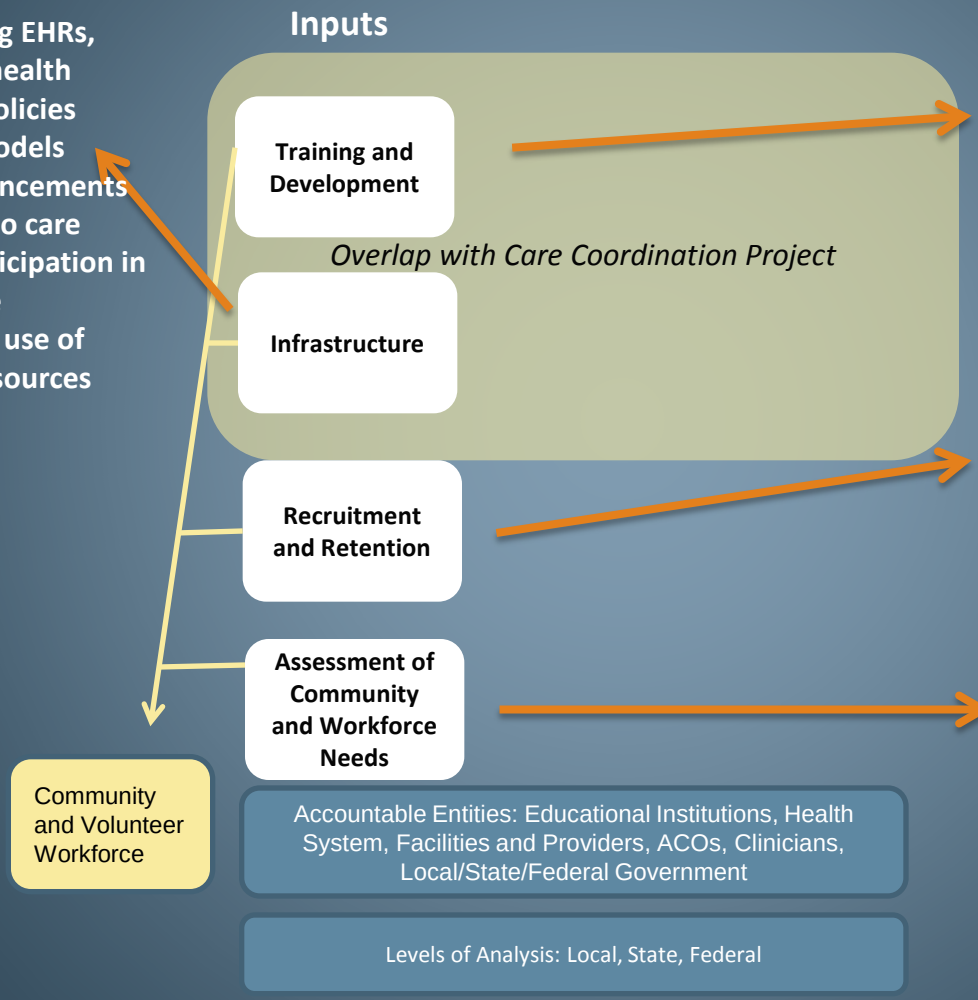


Framework for Action: Effective and Efficient Workforce Development and Deployment to Improve Care Coordination and Prevention

(focus on the professional/paraprofessional workforce)

- Use of HIT, including EHRs, Telemedicine, Telehealth
- Scope of practice policies
- Staffing policies, models
- Infrastructure enhancements to improve Access to care
- Organizational participation in new models of care
- Relationships with, use of community care resources



- Common Core Competencies in:
  - Interprofessional collaborative practice
  - Person-centered care
  - Patient and family engagement
  - Prevention methods
- Continuing education
- Faculty development and training
- Care in new delivery systems
- Practice Based Learning

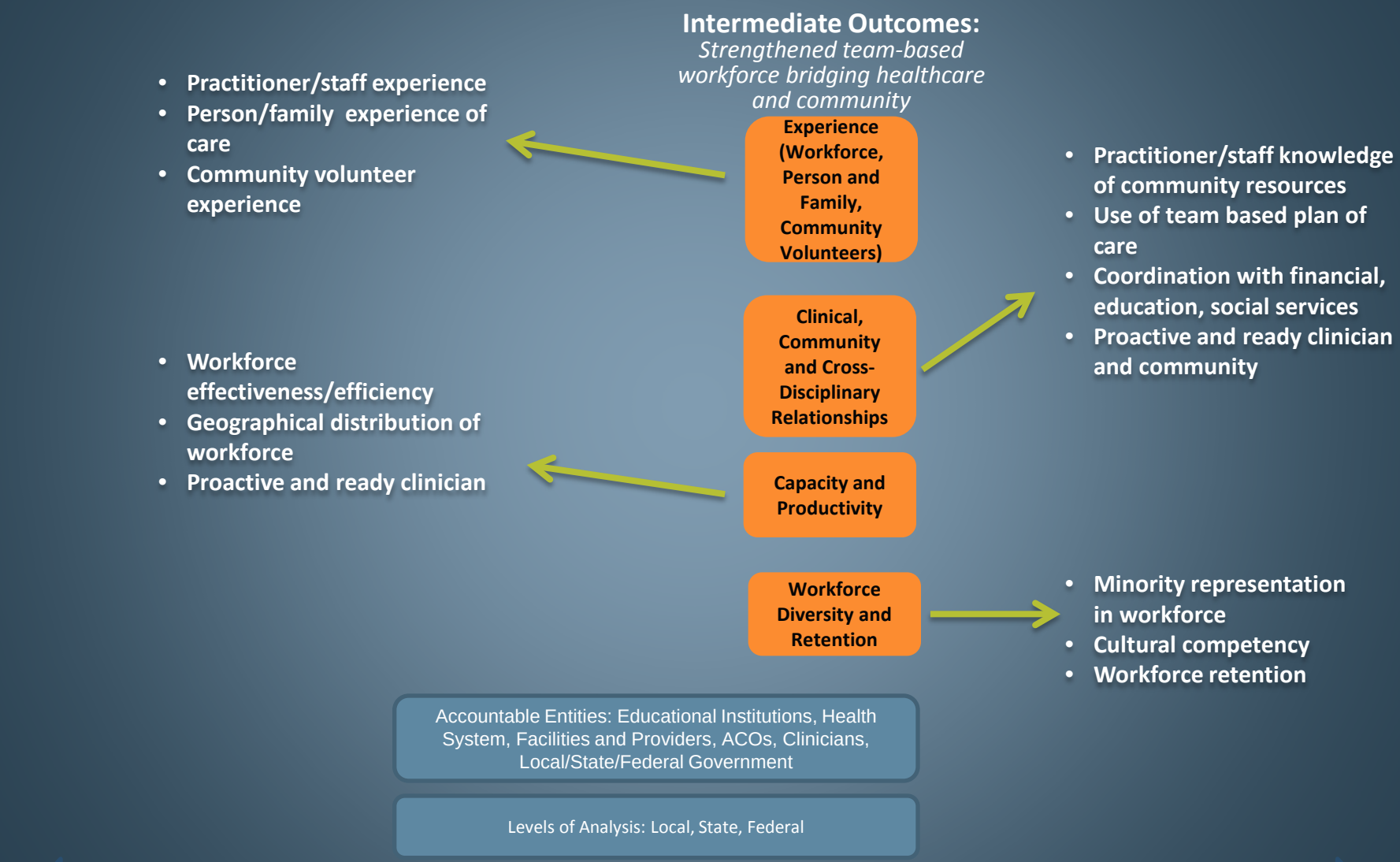
- Hiring and retention practices
- Workforce forecasting
- Needs based recruitment

- Team composition and function

Measurement Across the Lifespan

Framework for Action: Effective and Efficient Workforce Development and Deployment to Improve Care Coordination and Prevention

(focus on the professional/paraprofessional workforce)



Framework for Action: Effective and Efficient Workforce Development and Deployment to Improve Care Coordination and Prevention

(focus on the professional/paraprofessional workforce)

Longer Term Outcomes:
Enhanced health workforce readiness to improve prevention and care coordination

National Quality Strategy Aims
Healthy People and Communities
Better Care
Affordable Care

National Priority—Work with Communities to Promote Wide Use of Best Practices to Enable Healthy Living and Well-Being

National Priority—Promote Effective Communication and Care Coordination

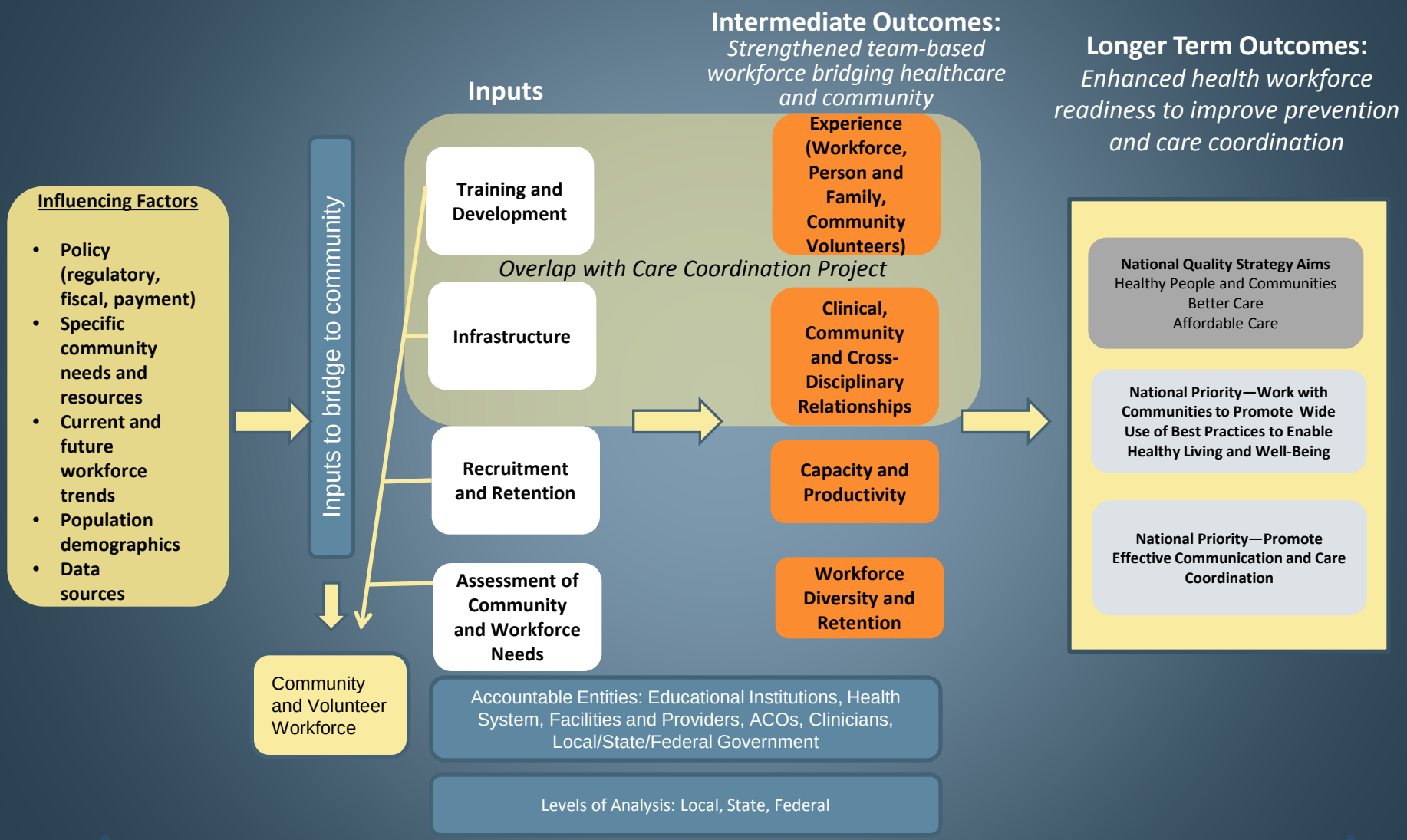
Accountable Entities: Educational Institutions, Health System, Facilities and Providers, ACOs, Clinicians, Local/State/Federal Government

Levels of Analysis: Local, State, Federal

Measurement Across the Lifespan

Framework for Action: Effective and Efficient Workforce Development and Deployment to Improve Care Coordination and Prevention

(focus on the professional/paraprofessional workforce)



Preliminary Environmental Scan of Measures

Preliminary Measure Scan Results

- Scan included a review of 5,962 measures
- 252 measures identified as potential health workforce measures

Environmental Scan of Measures by Domain

Health Workforce Domain	Number of Measures
Training and Development	99
Experience with Care	78
Workforce Capacity and Productivity	46
Infrastructure	34
Clinical, Community and Cross-Disciplinary Relationships	22
Staff Experience	7
Workforce Diversity and Retention	3
Recruitment & Retention	2
Assessment of Community and Workforce Needs	0

Input Into Environmental Scan

- Sources used in conducting the environmental scan:
  - NQF Portfolio
  - CMS 2013 Measures Under Consideration
  - HHS Inventory
  - Clinical-Community Relationships Measures Atlas
  - National Quality Measures Clearinghouse
  - Health Indicators Warehouse
  - Consultant survey

Input Into Environmental Scan

NQF Endorsed Measures

- Experience of Care
- Infrastructure
- Training and Development
- Capacity and Productivity
- Staff Experience
- Workforce Diversity and Retention

Gap areas

- Clinical, Community and Cross-Disciplinary Relationships
- Recruitment & Retention
- Assessment of Community and Workforce Needs

Input Into Environmental Scan

NQF Endorsed Measures, cont.

- #0204 – Skill Mix (RN, LVN/LPN, UAP, and contract)
- #0205 – Nursing Hours per Patient Day
- #0206 – Practice Environment Scale – Nursing Work Index (composite and five subscales)
- #0486 – Adoption of Medication E-Prescribing
- #0487 – EHR w/EDI Prescribing Used in Encounters Where a Prescribing Event Occurred
- #0488 – Adoption of HIT
- #0489 – Ability of providers with HIT to receive Laboratory data electronically directly into their qualified/certified EHR system as discrete searchable data elements
- #1888 - Workforce development measure derived from workforce development domain of the C-CAT
- #1892 – Individual engagement measure derived from the individual engagement domain of the C-CAT
- #1894 – Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT
- #1896 - Language services measure derived from language services domain of the C-CAT
- #1898 - Health literacy measure derived from the health literacy domain of the C-CAT
- #1901 – Performance evaluation measure derived from performance evaluation domain of the C-CAT
- #1902 – Clinician/Groups' Health Literacy Practices Based on the CAHPs Item Set for Addressing Health Literacy
- #1904 – Clinician/Groups' Cultural Competence Based on the CAHPS© Cultural Competence Item Set
- #1905 - Leadership commitment measure derived from the leadership commitment domain of the C-CAT
- #1919 - Cultural Competency Implementation Measure

Web Meeting Themes – January 28, 2014

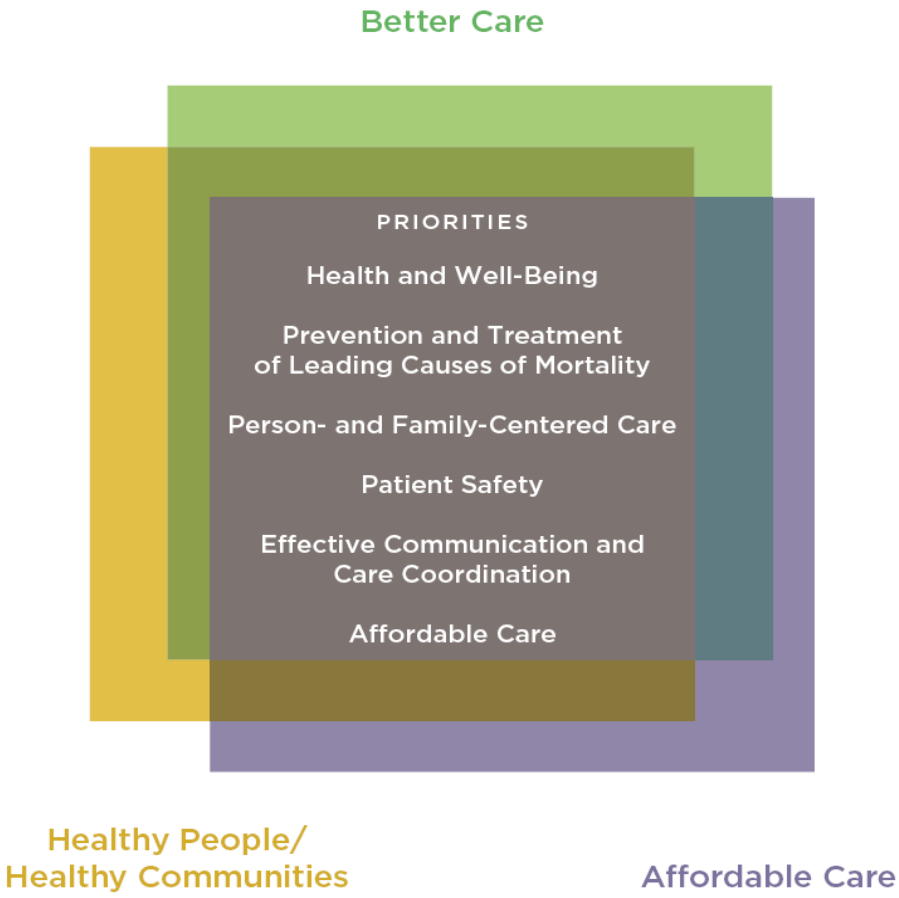
- An orientation of the Health Workforce Project was provided including background information on the Priority Setting for Health Care Performance Measurement and a review of the draft conceptual framework centered on health workforce deployment in terms of prevention and care coordination.
- Discussion of the framework domains and sub-domains geared towards concrete and highly actionable measure recommendations, focused on high-leverage and high-impact measurement areas, with an eye toward the future workforce:
  - Utilization of family caregivers as part of the health workforce
  - Utilization of information technology (IT) as a tool to improve care coordination and assurance of preventive services
  - Measure on actual health information exchange (HIT) where individuals are able to use collected information
  - Health workforce's readiness to assist individuals in meeting their personal health goals, as part of a long-term outcome
  - Health workforce competencies that will lead to improved patient's experience, ultimately leading to reduced cost

Committee Affirmation of Environmental Scan and Web Meeting Themes

Connecting NQF's Efforts to Prioritize Measure Gaps

Wendy Prins, Senior Director, NQF

National Quality Strategy



Priority Setting for Health Care Performance Measurement: 2013-14 Focus Areas

- Adult Immunizations
- Alzheimer's Disease and Related Dementias
- Care Coordination
- Health Workforce
- Person-Centered Care and Outcomes

Prioritizing Measure Gaps: Adult Immunization

Highest measurement priorities to optimize vaccination rates and outcomes across adult populations

- Measures for specific adult vaccines for which there are no NQF-endorsed measures (e.g., zoster, HPV, Td/Tdap)
- Summary or composite measures of adult immunization
- Outcome measures (e.g., hospitalizations, deaths, post-discharge readmission) for vaccine-preventable diseases
- Provider-level and population-level measures

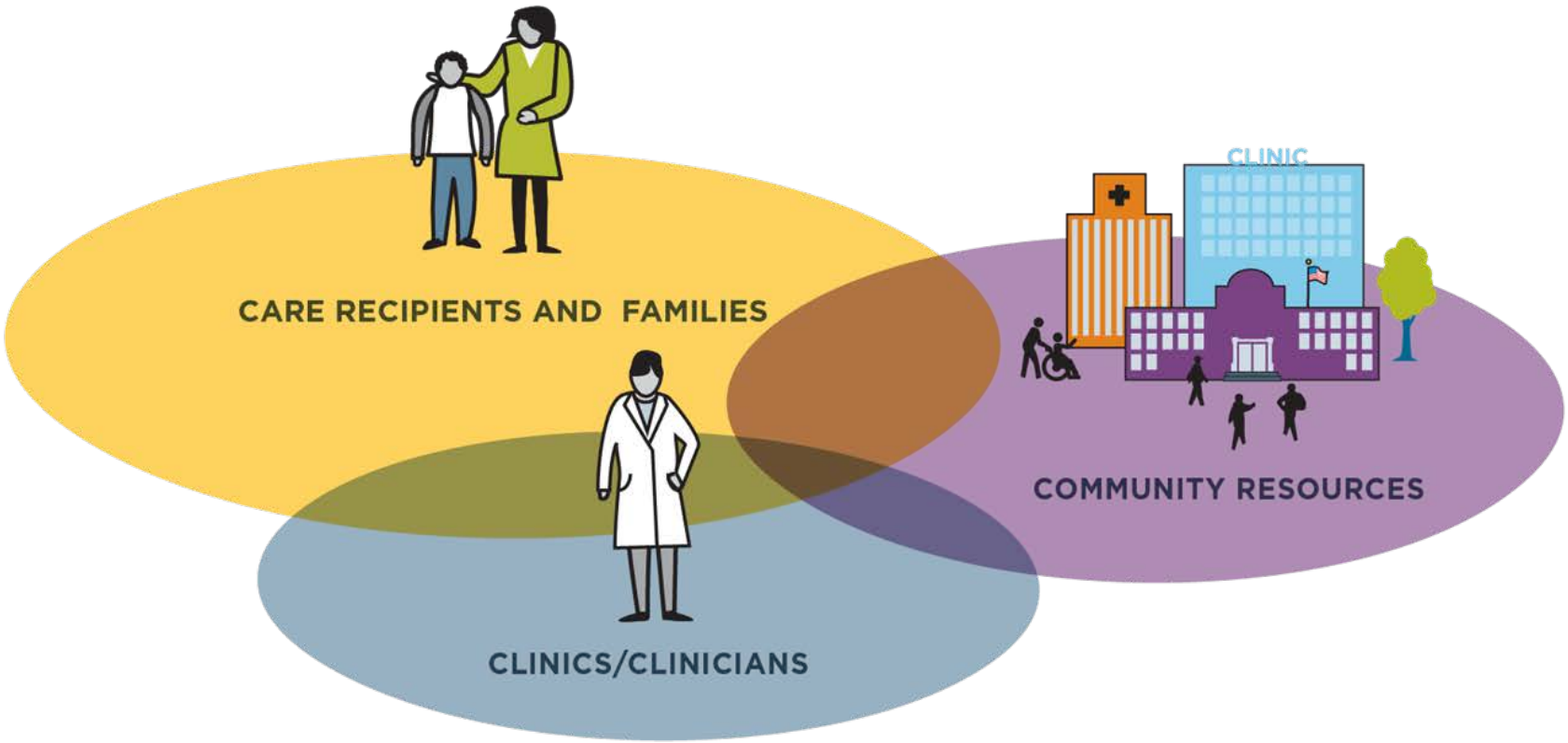
Prioritizing Measure Gaps: Alzheimer's Disease and Related Dementias

Highest measurement priorities to improve care and outcomes for persons with dementia and their families and caregivers

Five overarching measurement domains along the episode of care/disease trajectory (with corresponding subdomains) :

- Population at risk
- Symptom awareness and initial detection
- Evaluation and initial management
- Care, treatment, and support
- End-of-life and bereavement

Prioritizing Measure Gaps: Care Coordination



Joint Creation of Person-Centered Plan of Care	Utilization of the Health Neighborhood to Execute the Plan of Care	Achievement of Outcomes
Comprehensive Assessment	*Linkages/Synchronization*	*Progression Towards Goals*
• Document care recipient's current supports and assets • Assess function • Assess social needs • Assess behavioral health needs • Assess health needs • Assess medication management needs • Assess health literacy • Measure care recipient/family level of activation/engagement • Capture preferences and goals • Estimate risk level and customize CC approach accordingly • Estimate risk level • Continuous holistic monitoring	• Shared understanding by clinical providers, community providers and care recipients of goals • Appropriate community services identified and contacted based on needs assessment • Providers' awareness of value of community-based services • Care recipient/family successfully engages with and utilizes community services • Bi-directional communication to facilitate coordination • Frequent and accurate communication to solve problems	• Reduction of unmet needs, as documented in assessment • Services congruent with person-centered goals and preferences • Maximized health/functional status • Ensure patient safety • Increase care recipient/family level of activation
Shared Accountability		
• The plan of care documents members of the care team, including community providers • Plan of care assigns responsibilities for meeting care recipients' goals • Care team members are aware of and accept responsibility • System-level measure of accountability		

Prioritizing Measure Gaps: Person-Centered Care and Outcomes

Highest measurement priorities for person- and family-centered care with a working definition of

- An approach to the planning, delivery, and evaluation of care across settings and time that is anchored by, respectful of, and responsive to the individual's preferences, needs, and values.

Draft Core Concepts

- Know me and consider all of me in my care-health conditions, physical, mental, emotional, spiritual, and social
- Give me care when and how I need it
- Give me care that matches my preferences, values, goals, and decisions
- Treat me with respect and dignity
- Treat me as a partner in my care
- Include my family/caregiver when I choose and provide support to them
- Give me the information I need and want about my care or provider and to help me take care of myself
- Do not waste my time or add to my burden unnecessarily
- Communicate and cooperate with all of my providers of care

MAP Person- and Family Centered Care Family of Measures: Draft High-Leverage Opportunities/Measurement Areas

High-Leverage Opportunities	Measurement Areas
Experience of care (patients, families, caregivers)	• CAHPS • Satisfaction with care • Dignity, respect, compassion • Care coordination
Health-related quality of life	• Functional and cognitive status (assessment and improvement) • Mental health (assessment and improvement) • Physical, social, emotional, and spiritual support and well-being
Burden of illness	• Symptom and symptom burden (e.g., pain, fatigue, dyspnea) • Treatment burden (patients, family/caregiver, sibling, community)
Shared decision-making	• Patient, family and caregiver, and provider communication • Establishment and attainment of patient/family/caregiver goals • Advance care planning • Care concordant with individual values and preferences
Patient navigation and self-management	• Patient activation • Health literacy and cultural and linguistic competency • Caregiver needs and supports

Environmental Context and Measure Uses

Edward Salsberg, Research Faculty
George Washington University

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Health Workforce Performance Measurement: Environmental Context and Measurement Uses

Edward Salsberg

National Quality Forum

Health Workforce Committee

Washington DC

April 15, 2014

Workforce Goals

To have an adequate supply and distribution of well prepared and skilled health workers to assure access to high quality, efficient and effective care.

Includes: Prevention and care coordination to high need populations

Components of the Goals

- Adequate supply
- Adequate distribution
- Well prepared
- Skilled
- Access
- High quality care
- Efficient
- Effective
- Equity

The Health Workforce Marketplace: Many Diverse Stakeholders

- Federal and state policy makers (health, education and labor departments and state licensure boards)
- Universities, colleges, vocational schools, training programs (both private and public)
- Investors
- Credentialing bodies and professional associations
- Employers/providers (networks, hospitals, group practices, laboratories, etc.)
- Insurers
- Health workers and potential health workers

A Few Key Questions

- Do we need more now? In the future?
- Which occupations?
- What skills?
- Where do we need them?
- Is educational capacity sufficient?
- Are we using the workers we have effectively?
- What mix of workers yields the best results for at a reasonable cost?

Medicine Has Extensive Data

1. Data on applicants to medical school (socio-demographic/educational background)
2. Data on med school performance
3. Data GME
4. Certification – Recertification exams
5. Practice information
6. Billing information
7. The new Data Commons
8. Potential for research on quality and outcomes

Some Challenges and Opportunities

- HPSA/MUAs and the Negotiated Rule Making Committee: the need to combine supply and demand/need data
- The need for metrics on teams
- Distribution maybe a more significant problem than overall supply: geographical unit of analysis is critical
- The need to invest in health workforce research especially research linking workforce inputs and outcomes/efficiencies
- The importance of building on existing data collection investments: SOC; Census/ACS: licensure/credential

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THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

NQF Endorsement Criteria

Karen Pace, Senior Director, NQF

NQF Measure Criteria

(Healthcare) Performance Measurement

- Measures used for quantifying the performance of different aspects of the healthcare system
- Goal is to improve the quality of healthcare received by patients (and ultimately health)
- Types of performance measures
  - Quality
    - Outcome, including patient-reported outcomes
      - *Use of services (used as proxy for outcome, cost)*
    - Intermediate clinical outcome
    - Process
    - Structure
  - 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)

Types of Measures

- **Health Outcome** - health status of a patient (or change in health status) resulting from healthcare— desirable or adverse.
  - In some cases, **resource use** may be considered a proxy for a health state (e.g., hospitalization may represent deterioration in health status)
  - **Patient-reported outcomes** include health-related quality of life/functional status, symptom/ symptom burden, experience with care, health-related behavior
- **Intermediate Clinical Outcome -** a change in physiologic state that leads to a longer-term health outcome.

Types of Measures

- **Process -** healthcare-related activity performed for, on behalf of, or by a patient.
- **Structure -** a feature of a healthcare organization or clinician related to its capacity to provide high-quality healthcare

Overview of NQF Endorsement Criteria

NQF endorses performance measures based on an evaluation of the measure against a standard set of criteria to ensure it is suitable for use in accountability applications (e.g., public reporting, pay-for-performance), in addition to performance improvement.

NQF Criteria and Hierarchy

- Evidence, Performance Gap, Priority: Importance to Measure and Report (*must-pass*)
  - If does not meet this criterion, the other criteria less meaningful
- Reliability and Validity: Scientific Acceptability of the Measure Properties (*must-pass*)
  - If not a reliable and valid, risk of misclassification and improper interpretation
- Feasibility
  - Create as little burden as possible, or try to minimize burden
- Usability and Use
  - If no plan for use in accountability applications, NQF endorsement not necessary
- Comparison to Related and Competing Measures

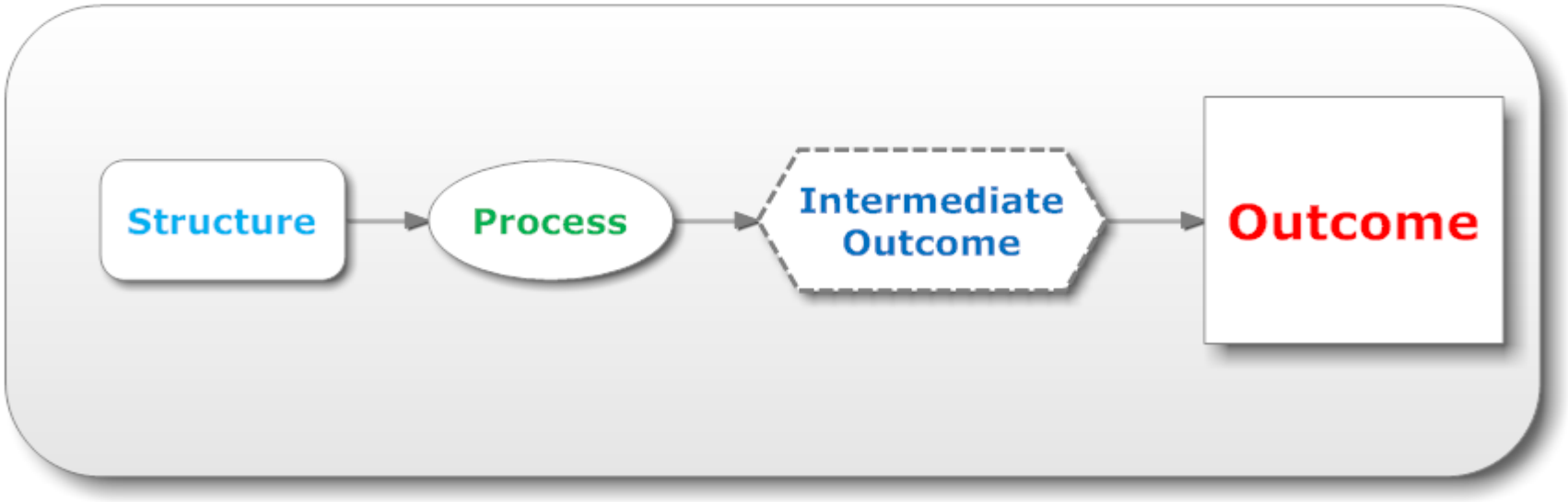
Performance Measure Concepts

- What structure, process or outcome should be measured?
- What patients (or personnel) should be included?
- What is the data source? (*e.g., personnel records*)
- Whose performance should be measured? (*e.g., hospital, ACO, health plan*)

Importance to Measure and Report – Applicable to Measure Concepts

- Evidence to Support the Measure Focus or Rationale for Outcomes, including PROs (*must-pass*)
  - Empirical evidence for structure, process, intermediate clinical outcomes
  - Outcomes – rationale influenced by at least one healthcare structure, process, intervention, service
- Performance Gap, including disparities (*must-pass*)
- High Priority (*must-pass*)
  - For PROs – information demonstrating it is valued and meaningful to patients/consumers
- For composite performance measures: quality construct and rationale (must-pass)

Structure-Process-Outcome

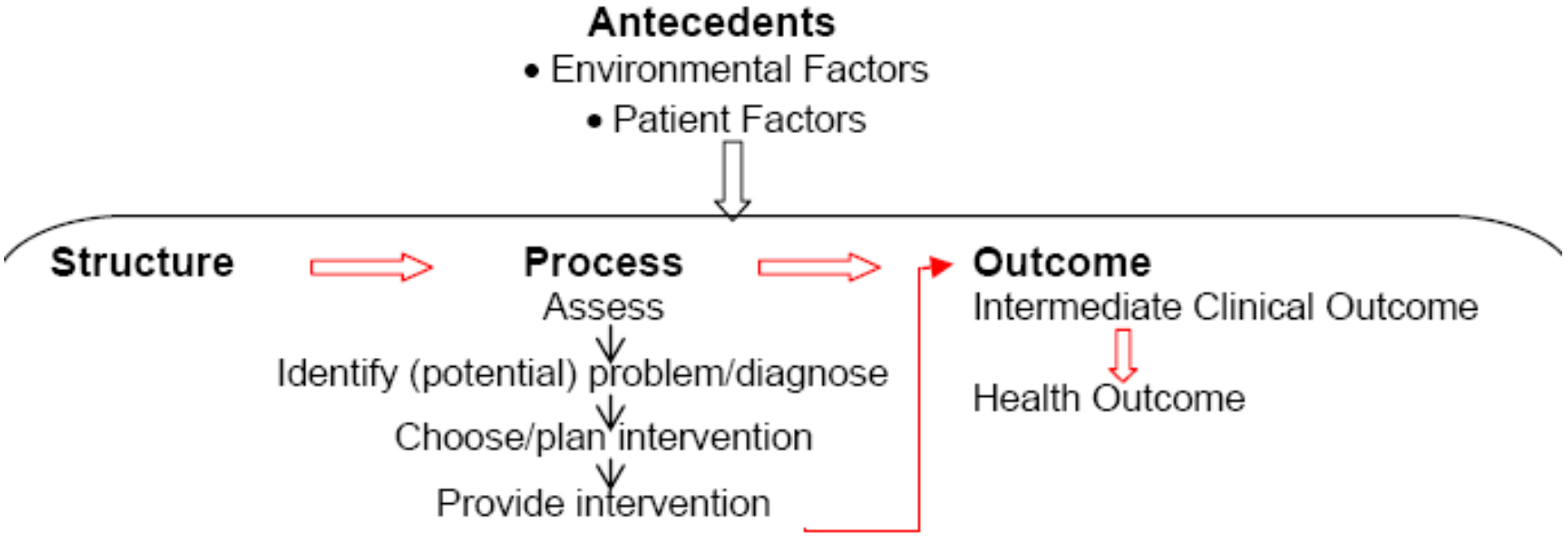


NQF – Hierarchical Preference for Measures of:

- Outcomes linked to evidence-based process/structures
- Outcomes of substantial importance with plausible process/structure relationships
- Intermediate outcomes
- Process/structures most closely linked to desired outcomes

Causal Pathway, Proximity to Outcome

- What are you measuring?
- What is the evidence about?



Key Questions to Consider for National Standard Performance Measures

- What are the desired outcomes?
  - Are they influenced by at least one process or structure?
- For structures or processes, is there evidence that indicates all specified entities should implement in their systems?
- Is there a performance gap?
- Is the outcome, process, or structure directly related to achieving a national priority?

Considerations for Performance Measurement

Considerations for Measurement

- Structure, process and outcome measures, including patient-reported outcomes
  - How can measures of the workforce promote improvements in deployment?
  - What measures are important to stakeholders?
  - How can measures promote improvements in care delivered by the workforce?

Considerations for Measurement

- Level of analysis
  - What is the most useful level of analysis – national, state, community, organization (employer, educational institution)?
  - What level(s) of analysis are likely to have the greatest impact in promoting improvements, national, state, community, organization (employer, educational institution)?

Considerations for Measurement

- Data sources
  - What are the pros and cons of the various data sources?
  - What are short-term considerations versus longer-term possibilities?

- Measure costs and burden
  - What are the cost/burden considerations for measurement?

Evaluate Draft Domains and Sub-Domains for Health Workforce Measurement

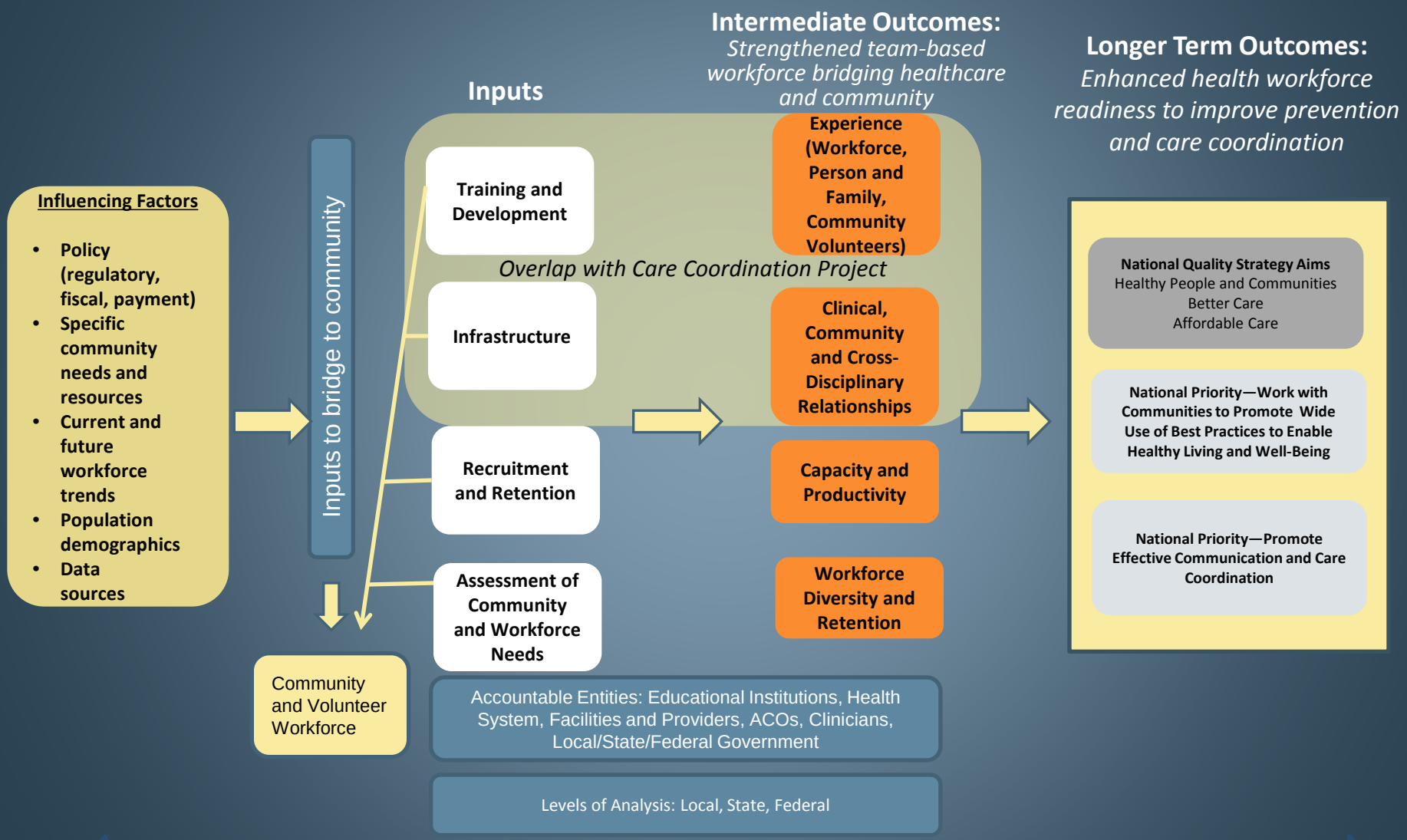
Crafting Measurement Domains and Sub-Domains Based on Homework Results

Methodology

- Introduced via email, committee ranked possible sub-domains of measurement for deployment of health workforce.
- Each member selected up to 15 sub-domains drawn from key sources.
- Participants also had the option to add additional sub-domains, as needed.
- Staff tallied the committee's votes for each sub-domain, domain grouped similar concepts

Framework for Action: Effective and Efficient Workforce Development and Deployment to Improve Care Coordination and Prevention

(focus on the professional/paraprofessional workforce)



Priority Domains – Rated by Homework Exercise

Infrastructure	Training and Development	Capacity and Productivity	Clinical, Community and Cross-Disciplinary Relationships	Workforce Diversity and Retention

Highest Priority

*In order of descending preference

Other domains:
Assessment of Community and Workforce Needs,
Experience (Workforce, Person and Family, Community Volunteers),
Recruitment and Retention

Top 15 Sub-Domains by Ranking

Ranking	Sub-Domain	Associated Domain
1.	Common Core Competency Sets	Training and Development
2.	Geographical distribution of workforce	Capacity and Productivity
3.	Workforce effectiveness/efficiency	Capacity and Productivity
4.	Use of team based plan of care	Clinical, Community and Cross-Disciplinary Relationships
5.	Team Composition and Function	Assessment of Community and Workforce Needs
6.	Use of HIT, Including EHRs, Telemedicine, Telehealth	Infrastructure
7.	Scope of Practice Policies	Infrastructure
8.	Workforce capacity (numbers of available providers)	Capacity and Productivity
9.	Organizational Participation in New Models of Care (ACOs, PCMH)	Infrastructure
10.	Relationships With, Use of Community Care Resources	Infrastructure
11.	Infrastructure Enhancements to Improve Access	Infrastructure
12.	Workforce forecasting	Recruitment and Retention
13.	Care in New Delivery Systems (ACOs, PCMHs, etc.)	Training and Development
14.	Practitioner/staff experience	Experience (Workforce, Person and Family, Community Volunteers)
15.	Continuing Education and Certification (Board)	Training and Development

“Middle of the Road” Sub-Domains by Ranking

Sub-Domain	Associated Domain
Cultural competency	Workforce Diversity and Retention
Person/family experience of care	Experience (Workforce, Person and Family, Community Volunteers)
Minority representation in workforce	Workforce Diversity and Retention
Practitioner/staff knowledge of community resources	Clinical, Community and Cross-Disciplinary Relationships
Coordination with financial, education, social services	Clinical, Community and Cross-Disciplinary Relationships
Workforce retention	Workforce Diversity and Retention
Faculty Development and Training	Training and Development
Practice Based Learning	Training and Development
Needs based recruitment	Recruitment and Retention
Proactive and Ready Clinician and Community	Clinical, Community and Cross-Disciplinary Relationships
Staffing Policies, Models	Infrastructure
Recruitment, training, and tracking back to underserved settings*	Training and Development; Recruitment and Retention

Should any of these sub-domains be elevated?

*** Added Subdomain**

Sub-Domains Receiving 1 or Fewer Votes

Sub-Domain	Associated Domain
Network adequacy/gaps in cohesion*	Assessment of Community and Workforce Needs
Family caregivers*	Assessment of Community and Workforce Needs
Community volunteer experience	Capacity and Productivity
Production of needed specialties*	Clinical, Community and Cross-Disciplinary Relationships
Job Security*	Clinical, Community and Cross-Disciplinary Relationships
Outcomes based compensation reform*	Clinical, Community and Cross-Disciplinary Relationships
Education level*	Clinical, Community and Cross-Disciplinary Relationships
Improved health outcomes*	Experience (Workforce, Person and Family, Community Volunteers)
Communication & Coordination of care*	Experience(Workforce, Person and Family, Community Volunteers)
NonProfit CHNA requirements (IRS) under ACA--these should include health workforce measures, interventions and evaluations*	Recruitment and Retention
Hiring and retention practices	Recruitment and Retention
Direct care workforce*	Recruitment and Retention
Developing career ladders*	Training and Development
Ability of workforce to meet need/demand* needs based recruitment?	Training and Development
Reduction of areas of underservice* geographical distribution?	Workforce Diversity and Retention
Outcomes-based recruitment* needs based recruitment	Workforce Diversity and Retention
Retraining existing workers for new roles*	Workforce Diversity and Retention
End of Life/Advanced Directive assurance and documentation	Other
Evidenced-base/Medically appropriate care	Other

*** Added Subdomain**

Should any of these sub-domains be elevated?

Thematic Clusters

Thematic Clusters

Infrastructure

Training and Development

Inputs

- Use of Health IT
- Access Enhancement
- New models of care
- Community connections and resources
- Scope of practice policies
- Staffing models

- Certifications
- Retraining

- Common core competencies
- Rigor of training

Thematic Clusters

Capacity and Productivity

Clinical
Community
Cross-Disciplinary
Relationships

Diversity and Retention

Intermediate Outputs

- Network adequacy
- Production of needed workforce/specialties
- Understanding worker experience of care
- Understanding geographical distribution
- Team based plans of care
- Interactions: public health, workforce, community resources
- Recognition of & community engagement to address social determinants of health
- Addressing workforce turnover; retention planning
- Workforce representative of community; reduction of underservice
- Culturally competent workforce

Thematic Clusters – Initial Measure Concepts INFRASTRUCTURE

Subdomain	Concept	Suitability
Use of HIT*	Adoption and use: of a certified/qualified EHR. (CMS) • Accountable Entity: Provider organizations, both public and private • Data Source	• Accountability
Scope of Practice	Assessment of practice agreements and SOP policies; degree to which workers can work to full training level • Accountable Entity: Practice sites • Data Source: NCQA data Flexibility in state licensing • Accountable Entity: State licensing authorities • Data Source: State licensing authorities	• Benchmarking • Improvement • Accountability • Benchmarking
Enhancements to Improve Access	Assess expanded hours, hiring/utilization of non-physicians for care delivery • Accountable Entity: Practice sites • Data Source: NCQA data	• Benchmarking
New Models of Care (ACO, PCMH)	Certification levels; outcome benchmarks • Accountable Entity: individuals, practices, systems • Data Source: Certifying groups' data	• Benchmarking • Improvement • Accountability
Community Resources	Presence of linkages between community resources and health care settings • Accountable Entity: Practices, ACOs, • Data source: Survey	• Benchmarking
Staffing Policies, Models	Assess CNAs, RNs with direct care responsibilities • Accountable Entity: Practices, ACOs,	• Improvement

Thematic Clusters – Initial Measure Concepts
TRAINING AND DEVELOPMENT

Subdomain	Concept	Suitability
Care in New Delivery Systems (ACO, PCMH); Practice Based Learning	Gained training/experience in; readiness to practice in new models of care. • Accountable Entity: health professions training programs • Data Source: ACGME CLER; accreditation data , other professions	• Benchmarking • Improvement • Accountability
Common Core Competency Sets	% Council on Education for Public Health (CEPH)-accredited schools of public health, academic programs, nursing schools integrating Core Competencies for Public Health Professionals into curricula. • Accountable Entity and Data Source: CME organizations, provider organizations, medical and graduate training programs Competency Assessment Instrument (CAI): Provider mean score on the "Community Resources" scale. • Accountable Entity: Healthcare Delivery System, Community Organizations	• Benchmarking • Improvement
Continuing Education	State requirements mandating continuing education • Accountable Entities: : Individuals • Data Source: state data	• Benchmarking
Faculty Development and Training	% faculty accredited to teach new models of care. • Accountable Entity: Individual faculty and schools/programs • Data Source: accrediting organizations	• Benchmarking

Thematic Clusters – Initial Measure Concepts
CAPACITY AND PRODUCTIVITY

Subdomain	Concept	Suitability
Workforce Effectiveness, Efficiency	Assessment of network adequacy • Accountable Entity: Insurance plans • Data Source: TBD % total productive nursing hours worked by LPN/LVN (employee and contract) with direct patient care responsibilities, by hospital unit • Accountable Entity: Delivery teams • Data Source: ANA management data	• Benchmarking • Improvement • Accountability • Benchmarking
Geographical Distribution	Workforce density and measures of community need • Accountable Entity: TBD • Data Source: HPSA, MUA, and comparable data sources; NAMCS, RHC staffing and other similar service structure and outcomes data resources	• Benchmarking
Capacity	Number of medical residents who completed primary care residency • Accountable Entity: Individuals • Data Source: Regional survey	• Benchmarking

Thematic Clusters – Initial Measure Concepts

CLINICAL COMMUNITY & CROSS-DISCIPLINARY RELATIONSHIPS

Subdomain	Concept	Suitability
Practitioner, Staff Knowledge: Community Resources	Population health; data sharing between public health and healthcare • Accountable Entity: community; practice sites • Data Source: multiple	• Benchmarking • Improvement • Accountability
Use of Team Based Plan of Care	Multidisciplinary care plan, utilization of "team" members' services. HIV: percentage of pediatric patients whose multidisciplinary care plan incorporates case management and nursing services. • Accountable Entity: practice • Data Source: TBD	• Improvement
Coordination: Financial Educational Social Services	Number/% patients referred to community health educator referral liaison (CHERL) • Accountable Entity: practice • Data Source: TBD Community solution teams who use 'hot-spotting' and other community analyses to identify populations, geographies that need multiple responses to improve care • Accountable Entity: community, practice • Data Source: multiple potential	• Improvement • Improvement
Proactive and Ready Clinician, Community	Functions/actions taken by organizations and clinicians to respond to patient and community needs • Accountable Entity: practice • Data Source: TBD	

Thematic Clusters – Initial Measure Concepts
WORKFORCE DIVERSITY AND RETENTION

Subdomain	Concept	Suitability
Minority Representation in the Workforce	Race, ethnicity balances • Accountable Entity: providers • Data Source: training matriculation data or collected data	• Benchmarking • Improvement • Accountability
Cultural Competency	% individuals who report their care provider explained things so they could understand them. The Cultural Competence Implementation Measure is an organizational survey designed to assist healthcare organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed® cultural competency practices prioritized for the survey.(RAND) • Accountable Entity: Recruitment and Training organizations, providers • Data Source: Patient Survey	• Benchmarking • Improvement • Accountability
Workforce Retention	Assessment of workforce turnover • Accountable entities: CNAs, HHAs, PCAs • Data Source: National Balancing Indicator Project; home care agencies; public authorities	• Improvement

Small Group Work: Generating Measure Concepts

Instructions for Activity

- Three groups brainstorm to create potential measure concepts for each of the measurement sub-domains.
- Choose a committee lead to report back to the main group
- Try to draft at least one measure concept for each sub-domain.
- Worksheets and staff recorders will help each group.

Instructions for Activity

- **Specific examples will be provided from the Measure Scan for the relevant subdomains**
- **Group concepts should include:**
  - **Description:** Nursing hours per patient day
  - **Numerator:** The number of productive hours worked by RNs with direct patient care responsibilities per patient day for each in-patient unit in a calendar month.
  - **Denominator:** Total number of patient days for each in-patient unit during the calendar month.
  - **Data source:** ANA management data

Group 1	Group 2	Group 3
Infrastructure; Clinical, Community and Cross-Disciplinary Relationships	**Training and Development; Experience of Care**	**Capacity and Productivity; Recruitment and retention; Workforce diversity and retention; Assessment of community needs**
Recorder: Angela, Conference Center	**Recorder: Allison, McPherson Room**	**Recorder: Laura, 9 Temporary**
Howard Berliner	Amy Khan	Evaline Alessandrini (phone)
Melissa Gerdes	Gail Macinnes	Christine Kovner
Tami Mark	Jean Moore	Ann Lefebvre
Sunita Mutha	Julie Sochalski	Peter Lee
William Pilkington	Greg Warshaw	John Snyder
John Schommer (phone)	Robert Moser (phone)	Charles VonGunten
Drew Zinkel	George Zangaro	

Report Out from Small Groups

- Please summarize your discussion for the group, highlighting:
  - Your group's potential measure concepts
  - The types of measures your group is seeking (e.g., process, outcome, experience)
  - Thoughts about impact and feasibility of measures
  - Data sources your group considered for measurement
  - Any other important themes!

Report Out

Opportunity for Public Comment

Summary of Day

Day 2: Wednesday, April 16, 2014

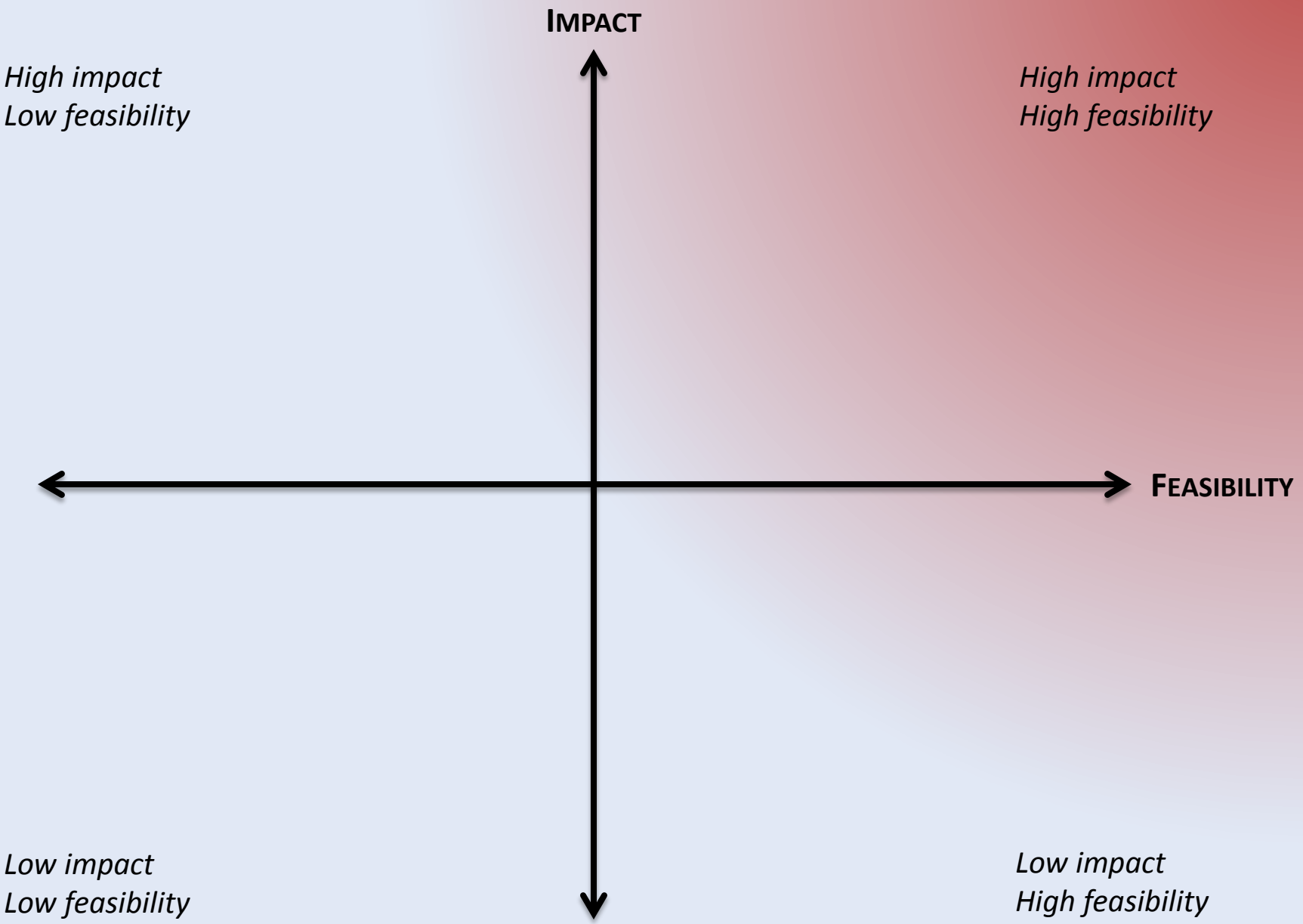
Welcome from NQF

Today's Agenda – Wednesday, April 16

8:30	Breakfast
9:00	Welcome from NQF
	Review Previous Day's Themes
9:15	Priorities Round up and Top Recommendations
10:30	Opportunity for Public Comment
10:45	Break
11:00	Final Measure Gap Prioritization Exercise
12:30	Lunch
1:00	Round-Robin Discussion of Themes and Future
	Development of Measures: Recommendations to HHS
1:45	Opportunity for Public Comment
1:50	Wrap Up/Next Steps
2:00	Adjourn

Review of Previous Day's Themes

Priorities Round Up and Top Recommendations


IMPACT
High impact
Low feasibility
High impact
High feasibility
FEASIBILITY
Low impact
Low feasibility
Low impact
High feasibility

Instructions for Activity

Discussion:

Assuming a trade-off between measures' impact and how easy it is to develop them, what is the most fertile ground for measure development?

- Full Committee Exercise:
  - Staff have placed concepts from small group work on Day 1 on "sticky wall"
  - Reach consensus on whether each is:
    - High or low impact
    - High or low feasibility

Opportunity for Public Comment

Final Measure Gap Prioritization Exercise

Final Measure Gap Prioritization Exercise Instructions

- Committee members have been given stickers indicating varying levels of priority: High, Medium and Low
- Members will place stickers on the concepts to indicate each member's assessment of priority
- Staff will summarize results

Round-Robin Discussion of Themes and Future Development of Measures: Recommendations to HHS

Committee's Suggested Themes for Forthcoming Report

- Take a few minutes to consider and share:
  - What areas for measure development have the most power to transform the deployment of the workforce?
  - What activities and associated measurements will be most powerful in producing better health?
  - What insights from this meeting should be emphasized in the forthcoming report?
  - What are short and long term recommendations regarding this topic that HHS should consider?

Opportunity for Public Comment

Wrap Up/Next Steps

Upcoming Activities

- **Mid-June:** Draft report available for public comment
- **June 30, 3-5 pm EST:** Webinar to present major findings and collect stakeholder feedback
- **August:** Final Report submitted to HHS and available on NQF website

Thank you for joining us!

Prioritizing Measure Gaps in the Health Workforce: Committee Exercise to Generate Potential Measure Concepts for Future Development

- This exercise focuses on the measurement opportunities related to the domains "Infrastructure" and "Clinical, Community and Cross Disciplinary Relationships "
- Together with your group, brainstorm potential ways to measure each of the subdomains in the conceptual framework.

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
Infrastructure	Use of HIT, Including EHRs, Telemedicine, Telehealth	1.			
		2.			
		3.			
Infrastructure	Scope of Practice Policies	1.			
		2.			
		3.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
Infrastructure	Organizational Participation in New Models of Care (ACOs, PCMH)	1.			
		2.			
		3.			
Infrastructure	Relationships With, Use of Community Care Resources	1.			
		2.			
		3.			
Infrastructure	Infrastructure Enhancements to Improve Access	1.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
		2.			
		3.			
Infrastructure	Staffing Policies, Models	1.			
		2.			
		3.			
Clinical, Community and Cross-Disciplinary Relationships	Use of team based plan of care	1.			
		2.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
		3.			
Clinical, Community and Cross-Disciplinary Relationships	Practitioner/staff knowledge of community resources	1.			
		2.			
		3.			
Clinical, Community and Cross-Disciplinary Relationships	Coordination with financial, education, social services	1.			
		2.			
		3.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
Clinical, Community and Cross-Disciplinary Relationships	Proactive and Ready Clinician and Community	1.			
		2.			
		3.			

Prioritizing Measure Gaps in the Health Workforce: Committee Exercise to Generate Potential Measure Concepts for Future Development

- This exercise focuses on the measurement opportunities related to the domains "Training and Development" and "Experience (Workforce, Person and Family, Community Volunteers)"
- Together with your group, brainstorm potential ways to measure each of the subdomains in the conceptual framework.

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
Training and Development	Common Core Competency Sets	1.			
		2.			
		3.			
Training and Development	Care in New Delivery Systems (ACOs, PCMHs, etc.)	1.			
		2.			
		3.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
Training and Development	Continuing Education and Certification (Board)	1.			
		2.			
		3.			
Training and Development	Faculty Development and Training	1.			
		2.			
		3.			
Training and Development	Practice Based Learning	1.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
		2.			
		3.			
Training and Development	Recruitment, training, and tracking back to underserved settings	1.			
		2.			
		3.			
Experience (Workforce, Person and Family, Community Volunteers)	Practitioner/staff experience	1.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
		2.			
		3.			
Experience	Person/family experience of care	1.			
		2.			
		3.			

Prioritizing Measure Gaps in the Health Workforce: Committee Exercise to Generate Potential Measure Concepts for Future Development

- This exercise focuses on the measurement opportunities related to the domains "Capacity and Productivity", "Recruitment and Retention", "Workforce Diversity and Retention" and "Assessment of Community and Workforce Needs"
- Together with your group, brainstorm potential ways to measure each of the subdomains in the conceptual framework.

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
Capacity and Productivity	Geographical distribution of workforce	1.			
		2.			
		3.			
Capacity and Productivity	Workforce effectiveness/efficiency	1.			
		2.			
		3.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
Capacity and Productivity	Workforce capacity (numbers of available providers)	1.			
		2.			
		3.			
Recruitment and Retention	Workforce forecasting	1.			
		2.			
		3.			
Recruitment and Retention	Needs based recruitment	1.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
		2.			
		3.			
Workforce Diversity and Retention	Cultural Competency	1.			
		2.			
		3.			
Workforce Diversity and Retention	Minority representation in workforce	1.			
		2.			

Conceptual Framework		*Potential Measure Concepts for Each Measurement Subdomain*			
Measure Domain	**Measure Subdomain**	**Measure**	**Numerator**	**Denominator**	**Data Source**
		3.			
Workforce Diversity and Retention	Workforce retention	1.			
		2.			
		3.			
Assessment of Community and Workforce Needs	Team Composition and Function	1.			
		2.			
		3.			

NATIONAL QUALITY FORUM

Interim Report from the National Quality Forum: Priority Setting for Health Workforce—A Draft Conceptual Framework and Draft Environmental Scan

December 16, 2013 (revised January 10, 2014)

This report was funded by the U.S. Department of Health and Human Services under contract number: HHSM-500-2012-00009I, Task 5.

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Project Purpose and Scope 1
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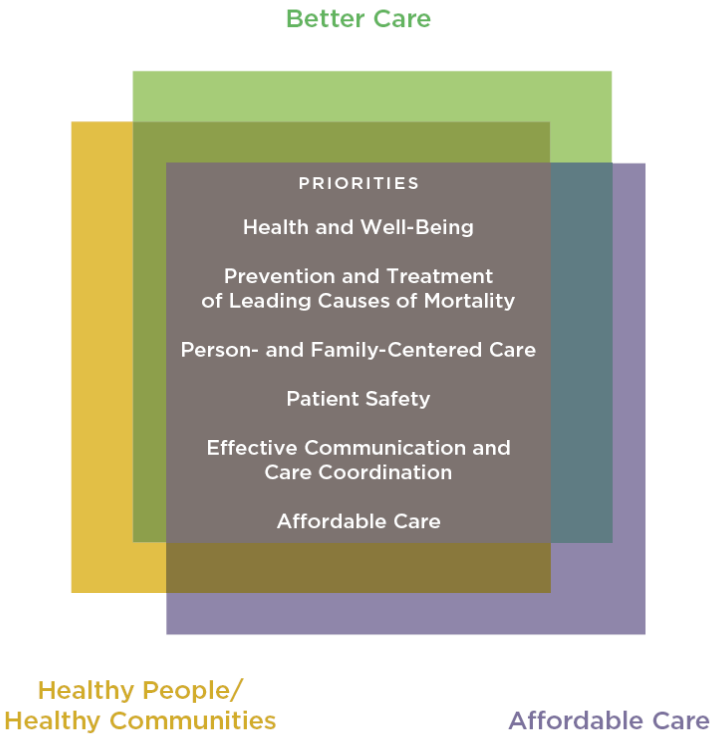
Appendix B: Framework References 12
Appendix C: Environmental Scan References 13

Project Purpose and Scope

Over the past ten years, the use of U.S. healthcare performance measurement has exploded, yet it is widely recognized that many gaps in important measurement areas still exist. Section 1890(b)(5) of the Social Security Act requires the National Quality Forum (NQF), as the consensus-based entity, to describe gaps in endorsed quality and efficiency measures in the Annual Report to Congress and the Secretary of the Department of Health and Human Services (HHS). Building on work done by NQF in 2011 and 2012 on the status of measure gaps more broadly, this project is intended to further advance the aims and priorities of the National Quality Strategy (Figure 1) by identifying priorities for performance measurement; scanning for potential measures and measure concepts to address these priorities; and developing multistakeholder recommendations for future measure development and endorsement.

Figure 1: National Quality Strategy Aims and Priorities



In 2013, HHS contracted with NQF to focus on five specific measurement areas, including:

- Adult Immunizations
- Alzheimer's Disease and Related Dementias
- Care Coordination
- Health Workforce
- Person-Centered Care and Outcomes

The recommendations generated through this project will be instrumental in aligning broader measure development efforts by ensuring that financial and human resources are strategically targeted to lead us to the measures that matter to patients and families, and that will drive improvement in health and healthcare.

Setting Priorities for Health Workforce Performance Measurement

Guided by a multistakeholder committee, this project will consider and prioritize opportunities to measure workforce deployment in the context of prevention efforts and care coordination. The work is intended to broaden the current scope of measurement related to workforce considering elements across the spectrum of healthcare delivery, and examine opportunities for measurement beyond healthcare delivery.

Research addressing the size and distribution of the healthcare workforce is plentiful but less attention has been given to the deployment of the healthcare workforce to promote effective prevention and care coordination—particularly for the elderly, individuals with multiple chronic conditions and complex care needs, critically ill patients, patients receiving end-of-life care, children with special needs, residents in long-term care settings, homeless people, and people who are dually eligible for Medicare and Medicaid. The focus of this work includes examining workforce education, training and skills to employ new team-based care approaches to provide high quality, culturally competent care, in order to increase the capacity of health organizations, medical homes and other new models of care delivery. The integration of electronic health records and interactive systems into infrastructures supporting the workforce, and recruitment and retention practices will also be explored. Another consideration will be mechanisms for shared accountability for population health between communities and the healthcare delivery system.

This work is intended to provide public and private stakeholders, including policymakers, healthcare providers and systems, and educational institutions with the resources and knowledge to advance performance measurement to optimally deploy the healthcare workforce in ways that promote effective prevention and care coordination.

General Approach and Timeline

NQF will use the approach and processes shown in Figure 2 and as detailed below to complete this project.

Figure 2: Four Step Process for Health Workforce Priority Setting Project

Convene Multistakeholder Committee

NQF will convene a 20-member committee with diverse representation and knowledge of workforce issues pertaining to prevention and care coordination, including representatives from the fields of primary care, behavioral health, allied health, public/population health, cultural competence and diversity, health disparities and safety net providers, Long-Term Services and Supports (LTSS) home and community-based care including both ambulatory and inpatient setting-based services, and consumers or their intermediaries. A small advisory group was formed immediately upon contract award to provide guidance to NQF on the draft conceptual measurement framework while the full committee was being seated. NQF met with the advisory group via web meeting in October 2013, and will meet with the full committee in a web meeting in January 2014, at an in-person meeting in April 2014, and once more by web in July 2014. Please see Appendix A for the full committee roster, which includes these advisors.

NQF also has engaged with a group of federal government partners—the DHHS Health Workforce Interagency Workgroup—in a consultative role. With ongoing exchanges between the two, it is expected that the work of these two groups will align well with and complement one another.

Identify a Conceptual Measurement Framework

In consultation with HHS and with input from advisory members, NQF will develop a conceptual framework for measurement that captures elements necessary for successful and measureable workforce deployment. The draft framework will offer measure domains and subdomains that align with the triple aim of improving health, quality, and cost. The framework will build on existing resources and frameworks listed in Appendix B, including NQF's *Multiple Chronic Condition Framework*, the Agency for Healthcare Research and Quality's (AHRQ) *Clinical-Community Relationships Measures Atlas* and *Care Coordination Measures Atlas,* and the Institute of Medicine's (IOM) *Health Professions Education: A Bridge to Quality*. The framework will be shared with the DHHS Health Workforce Interagency Workgroup for feedback. The framework is intended to complement the framework developed by NQF's parallel project focused on care coordination. Finally, the framework will be further informed and modified based on input from the full health workforce committee members once they are fully convened.

Environmental Scan of Measures and Measure Concepts and Analysis of Gaps

NQF staff, in consultation with the multistakeholder committee and DHHS colleagues, will complete an environmental scan of measures and measure concepts that map to the domains and subdomains of the identified conceptual framework, set for review by the full committee in the January 2014 web meeting. An initial scan to of the sources listed in Appendix C was conducted to identify measure concepts and performance measures and inform the early work of this project. These include structure, process, outcome, efficiency, patient experience, population health, and satisfaction measures as they pertain to effective prevention and care coordination through a workforce lens. While measurement of workforce deployment is in its infancy, measures were identified in the domains of training and development; infrastructure; recruitment and retention; experience; clinical,community and cross-disciplinary relationships; capacity and productivity, and workforce diversity and retention.

Committee Recommendations and Priorities for Performance Measure Development

The intent of this project is to provide guidance to the field regarding priorities for performance measure development, and additional research needs when the evidence is insufficient to provide a clear path to measurement in a priority area. In future meetings, the committee will discuss important considerations regarding measurement in this area including level of evidence, and feasibility of and challenges to

workforce measurement. These recommendations will be synthesized and submitted to HHS in a final report to be delivered in August 2014.

Draft Conceptual Framework

A wide range of measures will be needed to assess and improve health and healthcare quality to achieve the NQS aims of better care, affordable care, and healthy people and communities. This section of the report provides an overview of the draft conceptual framework that the multistakeholder committee will refine and use in its analysis and prioritization of measurement needs for the health workforce to improve prevention and care coordination.

The draft framework is expected to enable the committee to identify and prioritize areas for measurement and identify existing measures and measure concepts that could successfully address workforce deployment in targeted domains. The framework aims to connect workforce inputs--training and development, recruitment and retention, delivery system infrastructure and community integration supports, and assessment of community and workforce needs—with intermediate outcomes of improved experience of work and care, clinical, community and cross-disciplinary relationships, workforce capacity and productivity, and diversity and retention.

While focused on the professional and paraprofessional workforce, the use and roles of community health workers and safety net providers in promoting prevention and care coordination and reducing disparities in these areas is a key concept in the framework. The framework is intended to encompass measurement across settings and across the lifespan. The framework also envisions how these concepts could be measured through accountable entities and reported at appropriate levels of analysis. Key influencing factors such as policy and regulation, specific community needs and resources, workforce trends, population demographics and data sources also are represented in the framework. These reflect important overarching issues that may impact performance measurement and are intended to provide context to inform committee discussions.

As previously mentioned, NQF consulted existing frameworks as a starting point in developing a draft framework, guided by the recommendations of advisors, HHS, and a review of the literature. The following resources were particularly informative during this phase of the project:

- AHRQ's Care Coordination Measures Atlas (CCM Atlas)
- AHRQ's Clinical-Community Relationships Measures Atlas and Evaluation Roadmap (CCRM Atlas)
- IOM's Health Professions Education: A Bridge to Quality
- NQF's Multiple Chronic Conditions (MCC) Measurement Framework

Framework Definitions

Defining key terms related to workforce deployment is fundamental for measure development. Recognizing the importance of scoping the draft framework, NQF began by seeking early input from the advisors regarding definitions of key importance to this work, including the definition of workforce, primary care, care coordination, and health. The advisors recommended moving forward with the following working definitions.

Workforce. The World Health Organization (WHO) defines the healthcare workforce as "all people primarily engaged in actions with the primary intent of enhancing health." The WHO definition notes that workers are not just individuals but are integral parts of functioning health teams in which each member

contributes different skills and performs different functions. The advisors recommended including non-clinical workers as well as health systems workers to the definition, thus broadening the scope beyond traditional health caregivers. As a result, the term workforce includes the clinical workforce (e.g., physicians, nurses, behavioral health professionals, oral health professionals, allied health); the non-clinical workforce (e.g., public health and human service professionals); and long-term services and supports (LTSS) personnel. The concept of working at the "top of license/practice" will be examined in terms of increasing the effectiveness and efficiency of the workforce, particularly as workforce shortages in certain areas intensify.

Care Coordination. The advisory group agreed to adopt the CCM Atlas' broad definition of care coordination as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and often is managed by the exchange of information among participants responsible for different aspects of care." In keeping with the CCM Atlas, successes and failures in care coordination will be captured in the draft framework from the perspective of patients and families, healthcare professionals, and system representatives.

The CCM Atlas notes that patients perceive care coordination failures in terms of unreasonable levels of effort required on the part of themselves or their informal caregivers during transitions between healthcare entities. Healthcare professionals in turn consider instances when patients are directed to the "wrong" place in the healthcare system or have poor health outcomes as a result of poor handoffs or inadequate information exchanges as failures to effectively and efficiently coordinate care. They also perceive failures in terms of unreasonable levels of effort required on their part in order to accomplish necessary levels of coordination during transitions among healthcare entities. The CCM Atlas also includes the perspective of systems of care (e.g., accountable care organizations (ACOs)), whose goal is to integrate personnel, information, and other resources to carry out all required patient care activities between and among patients and families in order to better coordinate care. System representatives perceive failures in coordination as those that affect the financial performance of the system and when a patient experiences a clinically significant negative outcome resulting from fragmented care.

As recommended by the advisors, the experience of care coordination from the perspective of the community and volunteer workforce also will be considered since views from these different perspectives may be important for comprehensively measuring the performance of the health workforce in coordinating care and providing preventive care.

Primary Care. The advisors agreed to the IOM definition of primary care as "the provision of integrated, accessible health services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community." The definition was developed by the IOM Committee on the Future of Primary Care as part of a 2-year study to address opportunities for and challenges to reorienting healthcare to place greater emphasis on the function of primary care. Initial work on the draft framework also is informed by the CCRM Atlas, which focuses on the role of a primary care practice in providing for and recognizing the need for preventive health services, including arranging for the delivery of services not provided in the primary care setting (i.e., providing referrals to community resources), as well as the differentiation between clinics/clinicians and community-based resources.

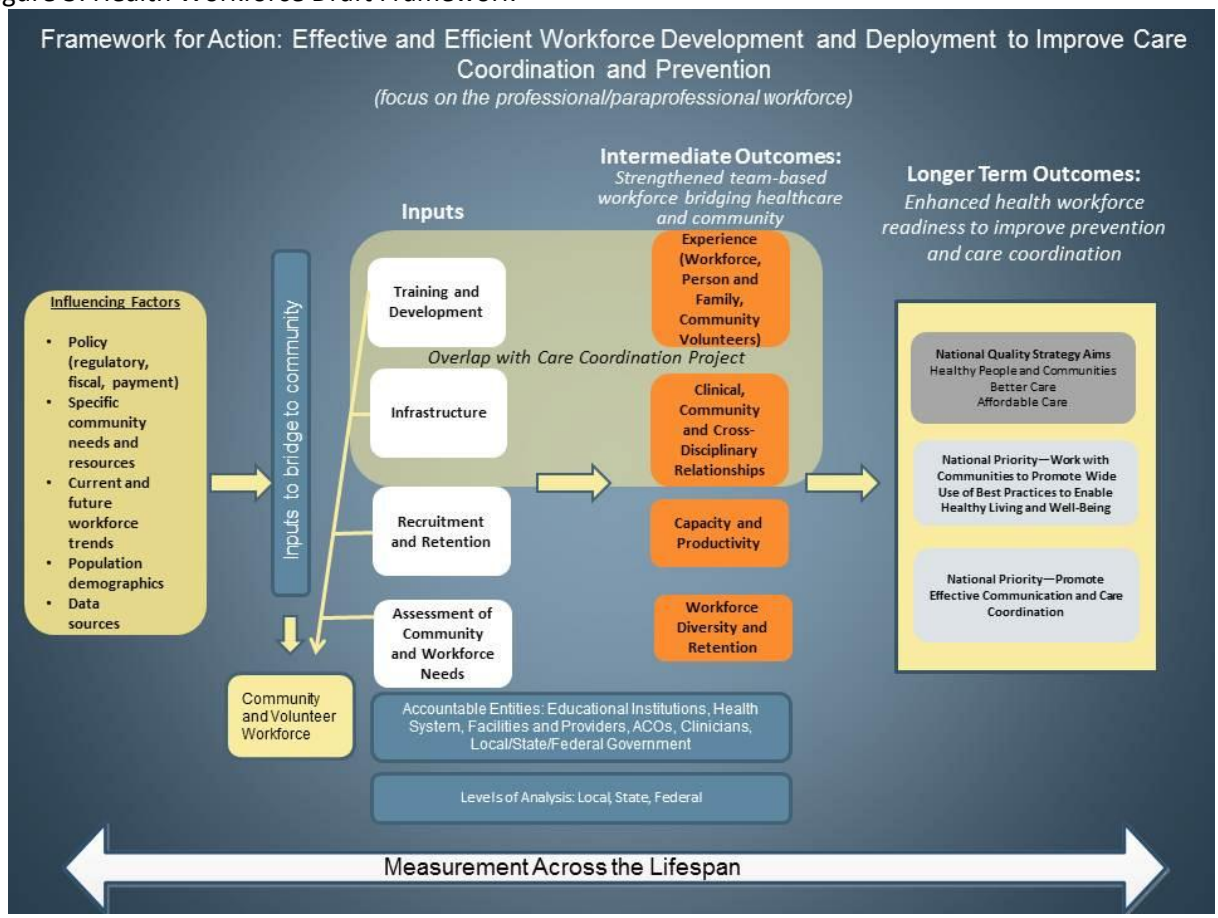
Health. Per the advisors' suggestion, the WHO definition of health will be incorporated into the work to reflect the goal of overall well-being: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Framework Structure

In conceptualizing the framework illustrated below in Figure 3, the advisors agreed that a framework for effective and efficient deployment of the health workforce to improve the coordination of patient care and improve prevention strategies should be grounded by the National Quality Strategy (NQS). They also recommended a broad approach to the framework, suggesting that it encompass measurement across the life-span and for measurement opportunities beyond clinical settings. With the potential for significant overlaps of inputs and intermediate outcomes with NQF's Care Coordination measure prioritization project, close coordination between project teams will be important.

While the framework will primarily focus on the paid professional and paraprofessional workforce as perhaps the most ripe and feasible areas for measurement, the advisors suggested capturing and examining the impact and roles of lay and community workers in the community setting (i.e., clinical-community impacts). This is consistent with the CCRM Atlas, which finds that a clinical-community relationship exists when a primary care clinician forges sustained relationships with community resources to provide certain preventive services such as tobacco screening and counseling or when the clinical practice and the community resource engage in at least one strategy for working together—networking, coordinating, cooperating, or collaborating. In the course of this work, inputs, intermediate outcomes, long-term outcomes, and influencing factors will be mapped in accordance with these guiding principles.

Figure 3: Health Workforce Draft Framework



Longer-Term Outcomes. Following discussions about the approach to this project, the advisory group recommended the logic model approach to the framework seen above. Beginning with the end in mind, the framework's overarching goals include the three broad aims of the NQS focused on better care, healthy people/communities, and affordable care. Although workforce is a critical element to achieve all six national priorities within the NQS, this project will take a specific focus on the priorities of prevention and care coordination, specifically:

- Working with communities to promote wide use of best practices to enable healthy living
- Promoting effective communication and coordination of care

These priorities will be one mechanism to ensure the project remains adequately focused and that the committee is able to develop clear priorities for a path forward.

Inputs. Guided by early feedback from the advisory group, the draft framework is oriented toward the professional and paraprofessional workforce. Inputs included in the framework are categorized as training and development, infrastructure, recruitment and retention, and assessment of community and workforce needs.

Training and development may include training that is intended to allow workers to deliver care in new models of care such as ACOs, patient centered medical homes (PCMHs) and dental homes, and other coordinated systems of care such as integrated healthcare networks that harmonize primary care with acute inpatient and post-acute long-term care. These models will require the caregiving disciplines to work together in a more coordinated effort over time. Faculty development and training should be included in this category to ensure education will reflect changes to the healthcare delivery system and interprofessional team-based care. In addition, continuing education will be critical to ensure the advancement of a workforce that will meet the needs of patients and the system.

The committee may consider recommending a common set of core competencies and training for specified workforce roles, such as:

- Interprofessional collaborative practice, readying the workforce to practice effective and team-based care;
- Person-centered care, including sensitivity to health literacy and cultural competency;
- Patient and family engagement and inclusion in care, including needs assessment, goal setting and creating plans of care;
- Quality measure data collection and reporting, including analyzing results and sharing best practices;
- Prevention methods, including guidelines, care standards, and literature analysis;
- Use of electronic health records (EHRs) and health information technology (HIT)
- Knowledge of and familiarity with community needs, norms, and resources and principles of population health;
- Practice-based learning and improvement, including an understanding of social science, economics, and professionalism; and
- Systems-based practice, including new models of care delivery (e.g., ACOs, PCMHs).

Infrastructure may address supports for clinicians, organizations, and systems to better coordinate people and processes. Measurement in this area may address the degree to which a sustainable organizational infrastructure exists to leverage technology and collaborative practice, to optimize service capacity and relationships between workforce and community, and to support the workforce in

efficiently and effectively improving quality. This category includes HIT infrastructure (such as use of EHRs and teleheath/telemedicine capabilities), scope of practice policies, enhancements meant to improve access to care, organizational structure, and delivery system design (including participation in ACOs, PCMHs, or other new models of care).

Recruitment and retention may encompass hiring practices and retention strategies, including those that improve diversity. This also includes onboarding, orientation, and career development to ensure employees are well trained and prepared to not only be effective healthcare providers, but to be confident and satisfied with their role. This will be critical and is expected to result in reduced turnover and higher employee satisfaction. Workforce forecasting and needs-based recruitment may also be considered within this category.

Assessment of Community and Workforce Needs may address strategies to measure the social, cultural or geographic needs of a given population or community in terms of workforce capacity and deployment. This will be critical to ensure an optimal workforce composition that possesses the necessary skills, cultural diversity and competency, or other critical elements to meet the needs of a specific community.

Intermediate Outcomes. The inputs previously described are expected to lead to the desired intermediate outcome of a strengthened team-based workforce, bridging health system resources with the communities they serve. Specifically it is expected that there will be improvement in workforce satisfaction and **experience of care delivery**, in patient and family experience of care, and in the community's experience interacting with the health workforce. It is expected that **clinical and community relationships** will be strengthened by increasing knowledge and familiarity of practitioners with community resources; using team-based plans of care; using surveillance systems to monitor population health; improving coordination with financial, education and social services to support patient care and strengthen inter-organizational relationships, all with the goal that both practitioners and community resources are proactive and ready in the provision of care.

Improved **workforce capacity and productivity** is anticipated, with improved effectiveness and efficiency in the provision of care and improved geographical distribution of the workforce. Capacities may be resources, such as infrastructure (including HIT), trained personnel, and response mechanisms that are utilized for workforce deployment (structural elements), while productivity may include functional actions that an organization is capable of taking to identify and respond to patient and community needs to deliver more efficient and effective care. **Diversity** and cultural competency of the workforce is expected to be improved with increased minority representation and improved cultural competency of the workforce. Finally, increased focus on workforce needs ideally will result in improved **retention**.

Ultimately, improvement in these areas is expected to improve the outcomes articulated in the NQS, and as part of the prioritization of measurement areas, the committee should articulate specific targets.

Influencing factors. The committee will need to consider measurement opportunities within the context of important influencing factors, including policy constraints such as regulations, fiscal realities, and changing payment models. Additionally, influencing factors include the diverse needs and resources of communities; current and future workforce trends and needs (e.g., an aging workforce); population demographics (including social and cultural factors); and data elements and sources needed to inform evidence-based measurement. A discussion of accountability and its potential for limiting measurement feasibility will also be considered, and may inform recommendations for future work.

Draft Environmental Scan of Measures and Measure Concepts

The accompanying Excel spreadsheet encompasses NQF's draft environmental scan of measures and measure concepts related to health workforce mapped to the framework domains specified above. The scan included a review of 5,962 measures imported from the sources listed in Appendix C. A total of 252 measures were identified as potential health workforce measures based on their broader applicability to the content area. When possible, measures and concepts were tagged according to the measurement domains emerging in the draft conceptual measurement framework described above. Table 1 provides a snapshot of the number of identified measures and their initial domain categorization. As the domains are not mutually exclusive, a small number of measures were thought to be relevant to more than one domain. The full draft scan was submitted as a deliverable to HHS.

Table 1: Environmental Scan of Measures by Domain

Health Workforce Domain	Number of Measures
Training and Development	99
Experience with Care	78
Workforce Capacity and Productivity	46
Infrastructure	34
Clinical, Community and Cross-Disciplinary Relationships	22
Staff Experience	7
Workforce Diversity and Retention	3
Recruitment & Retention	2
Assessment of Community and Workforce Needs	0

Large sets of measures were found related to training and development, mostly related to professional educational programs and the number of graduates in specific health professions. Although many measures of patient and family experience of care related to workforce performance were identified, few measures capturing workforce experience were found. Workforce capacity and productivity measures proved to have a substantial presence, especially those related to geographical distribution and skill mix. A significant number of measures related to infrastructure were also identified, a majority of which were specifically focused on the ability to use HIT to provide care and access to primary prevention services. Additionally, a significant number of measures addressing clinical, community and cross-disciplinary relationships, specifically the coordination of care with specific community resources was established. Considering the path forward for performance measurement, opportunities may exist for more measures on the other identified domains where there are few measures available or none at all.

Next Steps

Committee Input to Finalize Framework

The health workforce committee will meet via web in January 2014 and will provide input on the draft conceptual framework, consider high-priority opportunities for measure development and endorsement, and discuss promising measure, measure concepts and remaining gaps in critical measurement areas.

Continuation of Scan for Measures and Measure Concepts

Through the help of the committee, NQF will conduct an additional scan of measures and measure concepts to capture the finalized framework domains. Additionally, in early 2014 NQF will begin soliciting measure concepts through NQF's new Measure Inventory Pipeline, which will serve as an important source of information for HHS and other stakeholders on new measure development efforts in the broader healthcare community. NQF staff will conduct outreach to specific stakeholder groups to encourage the submission of measures that may address specific measure gap areas, and will encourage the committee to assist with this outreach.

Committee Recommendations on Priorities for Performance Measurement

A two-day in-person meeting is scheduled for April 2014 during which the committee will use its finalized framework and environmental scan to identify and prioritize gaps in quality measurement related to healthcare workforce deployment. The group will also identify areas in which quality measures are inadequate to address existing domains. The final conceptual framework, environmental scan and recommendations for prioritized measure development will be delivered to HHS in August 2014.

Appendix A: Health Workforce Committee Roster

COMMITTEE MEMBERS	
Evaline Alessandrini, MD, MSCE	Cincinnati Children's Hospital Medical Center
Howard Berliner, ScD	Service Employees International Union (SEIU)
Barbara Brandt, PhD	University of Minnesota
Melissa Gerdes, MD	Methodist Health System
Amy Khan, MD, MPH	Saint Mary's Health Plan
Christine Kovner, PhD, RN, FAAN	New York University, College of Nursing
Peter Lee, MD, MPH, FACOEM	General Electric
Ann Lefebvre, MSW, CPHQ	University of North Carolina at Chapel Hill
Gail MacInnes, MSW	Paraprofessional Healthcare Institute (PHI)
Tami Mark, PhD, MBA	Truven Health Analytics
Jean Moore, BSN, MSN	State University of New York at Albany School of Public Health
Robert Moser, MD	Kansas Department of Health and Environment
Sunita Mutha, MD	University of California San Francisco
Robert Phillips, MD, MSPH	American Board of Family Medicine
William Pilkington, PhD	Cabarrus Health Alliance
Jon Schommer, PhD	University of Minnesota
John Snyder, MD, MS, MPH (FACP)	Health Resources and Services Administration
Julie Sochalski, PhD, RN	University of Pennsylvania, School of Nursing
Charles vonGunten, MD, PhD	Ohio Health Kobacker House
Gregg Warshaw, MD, AGSF	University of Cincinnati College of Medicine
George Zangaro, PhD, RN	Health Resources and Services Administration
Andrew Zinkel, MD, FACEP	HealthPartners

DEPARTMENT OF HEALTH AND HUMAN SERVICES REPRESENTATIVES	
Cille Kennedy	Office of the Assistant Secretary for Planning and Evaluation
Girma Alemu	Office of Performance and Quality Measurement, Office of Planning, Analysis, and Evaluation

NATIONAL QUALITY FORUM STAFF	
Angela Franklin	Senior Director, Performance Measures
Allison Ludwig	Senior Project Manager, Strategic Partnerships
Severa Chavez	Project Analyst, Strategic Partnerships
Karen Adams	Vice President, Strategic Partnerships
Wendy Prins	Senior Director, Strategic Partnerships

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Health Workforce Committee

Performance Measurement

A quality performance measure is a numeric quantification of quality for an entity providing healthcare services. A performance measure score is based on an aggregation of data for the patients served.

NQF Criteria for Endorsing Performance Measures

NQF endorses performance measures based on an evaluation of the measure against a standard set of criteria to ensure it is suitable for use in accountability applications (e.g., public reporting, pay-for-performance), in addition to performance improvement. Because endorsement initiates processes and infrastructure to collect data, compute performance results, report performance results, and improve and sustain performance, NQF endorsement is intended to identify those performance measures that are most likely to facilitate achievement of high quality and efficient healthcare for patients. NQF's criteria are organized around five major concepts with subcriteria that further describe how the main criteria are demonstrated. The criteria are arranged in a hierarchy for review and evaluation as follows.

Main criteria

- **Importance to Measure and Report** (this is not the same as "Important to do") - Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. This is a must-pass criterion. If a measure does not meet the importance criterion, then the other criteria are less meaningful.

- **Reliability and Validity: Scientific Acceptability of the Measure Properties** - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. This is a must-pass criterion. The goal of measuring performance is to make valid conclusions about quality; if a performance measure is not reliable and valid, there is a risk of misclassification and improper interpretation.

- **Feasibility** - Extent to which the specifications, including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement. Ideally, performance measurement should create as little burden as possible; however, if an important and scientifically acceptable measure is not feasible, alternative approaches and strategies to minimize burden should be considered.

- **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 to achieve the goal of high-quality, efficient healthcare for individuals or populations. NQF-endorsed measures are intended to be used for decisions related to accountability and improvement. New measures should have a credible plan for implementation in accountability applications and rationale for use in improvement. Measures undergoing endorsement maintenance are expected to be in use.

- **Comparison to Related and Competing Measures** - If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure. Duplication and lack of harmonization among performance measures create burdens related to inefficient use of resources measure development, increased data reporting requirements, and confusion when they produce conflicting results.

Importance to Measure and Report

When identifying measure concepts for potential performance measures, the first consideration is whether it will meet the first major criterion of *Importance to Measure and Report*. There are many things that are important to do in clinical practice, yet not all of these things necessarily rise to the level of importance required for endorsement by NQF as a national consensus standard for measuring performance. NQF has a hierarchical preference for performance measures of health outcomes (including patient-reported outcomes) as follows:

- Outcomes linked to evidence-based processes/structures
- Outcomes of substantial importance with plausible process/structure relationships
- Intermediate outcomes that are most closely linked to outcomes
- Processes/structures that are most closely linked to outcomes

There are four subcriteria to demonstrate whether the Importance criterion is met (Box 1).

Box 1. Importance to measure and report (must-pass)
1a. Evidence to Support the Measure Focus or Rationale for Outcomes, including PROs (must-pass)
1b. Performance Gap, including disparities (must-pass)
1c. High Priority (must-pass)
1d. For composite performance measures: quality construct and rationale (must-pass)

Subcriterion 1a: Evidence

This subcriterion is meant to address the question of whether there is an adequate level of empirical evidence to support a measure for use as a national consensus standard. The assumption underlying this subcriterion is that use of limited resources for measuring and reporting a measure is justified only if there is unambiguous evidence that it can facilitate gains in quality and health. For most healthcare quality measures, the evidence will be that of clinical effectiveness and a link to desired health outcomes (e.g., improved clinical outcomes, functional status, or quality of life; decreased mortality; etc.). Evidence refers to empirical studies, but is not limited to randomized controlled trials. Because not all healthcare is evidence-based, NQF will allow—under certain circumstances—an exception to the evidence subcriterion; however, granting of such exceptions should not be considered routine.

For health outcome measures and patient-reported outcome performance measures (including experience with care), NQF does not require a summary of a systematic review of the empirical evidence that links the outcomes to certain processes and/or structures of care because there are myriad processes and structures that may influence health outcomes. However, NQF does require that developers of these types of measures articulate a rationale (which often includes evidence) for how the outcome is influenced by healthcare processes or structures.

Subcriterion 1b: Performance Gap
This subcriterion is meant to address the question of whether there is actually a quality problem that is addressed by a particular measure. Again, because the measurement enterprise is resource intensive, NQF's position is to endorse measures that address areas of known gaps in performance (i.e., those for which there is actually opportunity for improvement). Opportunity for improvement can be demonstrated via data that indicate overall poor performance (in the activity or outcome targeted by the measure), substantial variation in performance across providers, or variation in performance for certain subpopulations (i.e., disparities in care).

Subcriterion 1c: High priority
This subcriterion is meant to address the question of whether the focus of a particular measure addresses a specific national health goal or priority and/or a high-impact aspect of healthcare. For example, the property of "high priority" is demonstrated when a measure is aligned with one of the National Quality Strategy priorities or with a specific national health goal (e.g., reducing hospital readmissions). Alternatively, a measure can be considered as addressing a high-priority aspect of healthcare if epidemiologic or resource use data demonstrates that the measure can affect large numbers of patients and/or has a substantial impact for a smaller population, if the associated condition is a leading cause of morbidity/mortality, and/or if the associated condition results in high resource use (current and/or future), high illness severity, or if the consequences of poor quality would severely impact patient or societal health.

Subcriterion 1d: Quality construct and rationale (relevant to composite performance measures only)
A composite performance measure is a combination of two or more component measures, each of which individually reflects quality of care, into a single performance measure with a single score. CAHPS "composites" that include multiple questions are not considered composite performance measures for purposes of NQF evaluation and endorsement because the individual questions would not be stand-alone performance measures. The first step in developing a composite performance measure should be to articulate a coherent quality construct and rationale to guide construction of the composite. Once this is determined, the developer should select which component measures will be included in the composite measure and determine how those components will be combined.