NATIONAL QUALITY FORUM

Meeting Summary

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

Health Workforce Committee Meeting

The National Quality Forum (NQF) convened an in-person meeting of the Prioritizing Measure Gaps: Health Workforce Committee on April 15-16, 2014. An online archive of the meeting will be available on the project page.

Committee Members in Attendance

Name	Organization
Melissa Gerdes, MD *(Co-chair)*	Methodist Health System
Ann Lefebvre, MSW, CPHQ *(Co-chair)*	University of North Carolina at Chapel Hill
Evaline Alessandrini, MD, MSCE	Cincinnati Children's Hospital Medical Center
Howard Berliner, ScD	SEIU
Amy Khan, MD, MPH	Saint Mary's Health Plan
Christine Kovner, PhD, RN, FAAN	NYU College of Nursing
Peter Lee, MD, MPH, FACOEM	General Electric
Tami Mark, PhD, MBA	Truven Health Analytics
Jean Moore, BSN, MSN	SUNY Albany School of Public Health
Robert Moser, MD	Kansas Department of Health and Environment
Sunita Mutha, MD	University of California San Francisco
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
Gregg Warshaw, MD, AGSF	University of Cincinnati College of Medicine
George Zangaro, PhD, RN	Health Resources and Services Administration
Andrew Zinkel, MD, FACEP	HealthPartners

Day 1: Tuesday, April 15, 2014

Welcome and Review of Meeting and Project Objectives

Committee co-chairs Melissa Gerdes, MD and Ann Lefebvre, MSW, CPHQ welcomed committee members and the public audience to the meeting and provided opening remarks about the importance of this work. After introductions, Ms. Lefebvre reviewed the meeting objectives which were to:

- 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

HHS Opening Remarks

Ann Page from the Office of the Assistant Secretary for Planning and Evaluation, HHS, provided opening remarks and underscored relevant themes to the discussion. She emphasized that the goal of the measure gaps prioritization project is to develop measures that provide both quantitative and qualitative descriptions on how a capable, efficient, and person-centered care can be deployed. Girma Alemu the government subtask lead from the Office of Planning, Analysis, and Evaluation, at the Health Resources and Services Administration (HRSA) also provided opening remarks and highlighted the importance of this project to the future work of HHS.

Review Project Progress to Date

Angela Franklin, Senior Director, NQF, reviewed the project's core elements and progress to date, including: a WHO definition of health workforce and the development of the draft conceptual framework. Ms. Franklin asked committee members to consider how the conceptual framework might be edited further, particularly with regard to the focus on paid professionals and paraprofessionals, expected accountability measures, and expected levels of analysis. Committee members suggested refinements for the conceptual framework, including the following:

- The work of the family and caregivers should also be represented and considered as part of the health care workforce rather than called out separately
- Measuring the level of communication by and among the workforce is essential to identifying contributing factors to person-centeredness and capturing the elements of how different people are engaged, and
- The conceptual framework should reflect how end-users will use measures of workforce deployment for prevention and care coordination.

Allison Ludwig, Senior Project Manager, NQF presented the results of the environmental scan and web meeting themes from January. The results of the environmental scan identified three main gap areas including: clinical, community and cross-disciplinary relationships, recruitment and retention, and assessment of community and workforce needs.

Connecting NQF's Efforts to Prioritize Measure Gaps

Wendy Prins, Senior Director, NQF, presented on other Prioritizing Measure Gaps topic areas and the work of the MAP Person- and Family-Centered Care Task Force. Ms. Prins emphasized NQF's broad outlook to identifying measurement opportunities to support an adequate health workforce.

Committee members were very engaged in the discussion and provided guidance regarding measurement strategies to promote improvements in workforce deployment, emphasizing that the term workforce encompasses both individual providers and their mix of skills. Members discussed measures of skills and training, access, communication, and measures of efficiency, linked with indicators of quality. Member discussion included the role of interdisciplinary teams, direct care workers and shared accountability on a systems level. The discussion also identified the challenges in regulation due to variation by state, lack of communication between different levels of care, and encouraging providers to work at the top of their licenses.

Environmental Context and Measure Uses

Edward Salsberg, Research Faculty, George Washington University, provided an overview on the Health Workforce Performance Measurement: Environmental Context and Measurement Uses. Mr. Salsberg described the goals of the workforce to be adequate, equitable, accessible, and efficient in order to provide effective and high quality coordinated care to a high needs population. He particularly emphasized the need to communicate with multi-stakeholder policy makers, including universities and accrediting institutions, as well as using current medical data to build the foundation for future measure development and a strong health workforce.

Committee members agreed that the information presented was fundamental to this project. From an economic perspective, members noted that applying the concept of supply, demand, and need is helpful in understanding the current constraints in workforce deployment and adequately projecting the prospective needs of the health workforce overall. The discussion also identified the need to incorporate social services as part of the health workforce.

NQF Endorsement Criteria

Karen Pace, Senior Director, NQF, presented on the Consensus Development Process used for measure endorsement. Ms. Pace emphasized the importance of strategically analyzing a measure in order to improve the quality of health care delivery to consumers. An example of measuring immunization status through vaccinations was used to describe NQF's interest in endorsing measures that achieve interventions leading to outcomes. NQF has endorsed a handful of health workforce measures, but significant gaps remain. Ms. Pace emphasized this project as an important opportunity to address upstream the need for new, cross-cutting, and meaningful measures of health workforce.

Considerations for Performance Measurement

Dr. Gerdes and Ms. Lefebvre proposed key questions to the committee to consider for measurement regarding measures that are important to stakeholders and that will promote improvements in workforce deployment and measures. The primary outcomes of this discussion were:

- Measuring the level, timeliness, and effectiveness of communication between direct care providers and the consumer/caregiver in order to evaluate the skill level of the worker and baseline knowledge of the caregiver
- Measuring access to care, particularly in rural areas, as well as how much home health is available to the consumer
- Measuring costs vs. purchasing power of consumers for health plans to ensure that the right type of care can be supplied to meet the demands
- Measuring the needs of the consumer as the most important stakeholder as well as understanding the perspective of the payer in order to achieve a balance
- Measuring the use of various resources available to deliver person-centered care (e.g. technology that brings care to the individual)
- Measurement of a team based approach to person centered care to gain insight on the level of interdisciplinary care provided to consumers, and
- Measuring the adequacy of the education and training around prevention.

Dr. Gerdes led a discussion regarding measurement at particular levels of analysis, and the potential impact and usefulness of measures, depending on the level of analysis. Committee members suggested various levels of analysis for measurement including measures assessing workforce deployment at the community, educational institution, health plan, and provider levels.

Ms. Lefrebvre led a discussion of the pros and cons of various data sources and potential costs and burdens associated with measurement. Committee members suggested a variety of data sources for measure development including: public sources such as census data; the literature; universities; community based organizations; practitioner data from employers, certifications and renewals; patient data from surveys, and administrative claims data. Members also suggested that accessing some pools of data may require the development of relationships. Committee members agreed the funding for data source development is an influencing factor and that it is important to first determine what metrics of workforce deployment will deliver real impact, and allow that to inform what data sources are needed to support measurement. For example, by looking at demand and understanding what professionals are most needed and cost effective in terms of outcomes and quality, developers would be able to understand the pressing workforce needs. Committee members also discussed the importance of retraining the current workforce using HIT to develop new skills in order to meet the demands and contribute to data collection. The committee agreed that it is important to understand from providers and other measure end-users what is needed to meet the measurement burden, and that existing data collection efforts should be leveraged.

Overall, the committee agreed measurement must begin by assessing the needs of the population being served in order to understand which improvements to the system are required. In some cases, the information gathered from measurement would fill gaps in evidence and would be useful to policy makers, workforce developers, and the current health workforce in achieving progress.

Evaluate Draft Domains and Sub-Domains for Health Workforce Measurement

Ms. Franklin and Ms. Ludwig presented an overview of the committee's work, completed prior to the meeting, to construct draft domains and subdomains of health workforce measurement. Dr. Gerdes facilitated a group discussion reviewing the domains and the following key themes emerged:

- In the *Training and Development* domain, a larger paraprofessional workforce is needed, and geriatric training and extent to which providers will be able to provide for aging populations.
- Regarding *Capacity and Productivity,* review evidence from the Money Follows the Person (MFP) Rebalancing Demonstration to determine barriers to care and workforce retention in primary care. Also acknowledging that there are many challenges to measuring the extent to which there is a lack of workers (or what workers are in demand) and assessing current workforce distribution by geographical location.
- In the domain of *Clinical Community and Cross-Disciplinary Relationships,* assess whether increasing the number of referrals to various providers impacts efficiency and highlight the importance of maintaining positive and sustainable relationships between provider and consumer. Conduct more analyses of turnover rates and determine reasons for workforce attrition. Clarify what is meant by the term 'retention' under *Workforce Diversity and Retention.*

Small Group Work: Generating Measure Concepts

Committee members then divided into three sub-groups to brainstorm potential measure concepts for each of the measurement sub-domains. The Committee then reconvened and shared their progress in creating potential measure concepts with their respective groups as well as additional potential concepts:

Domain	Measure Concept
Assessment Of Community Workforce Needs	Evaluate the composition of the composition of teams that are performing well on national measure sets
Recruitment And Retention	Level of standard deviation from ideal forecasting at the state level
	Amount of standard deviation from ideal workforce retention and recruitment by discipline (data/evidence based development needed)
Workforce Diversity And Retention	Retention as measured in: discipline area, geographic location, organization, industry, employment vs. unemployment
	Mean score on existing standardized tools for patient experience as it pertains to cultural competecy
	Community level minority representation of workforce as represented in census data
Capacity and Productivity	General Health Proxy: Infant mortality rate in country or state as compared to workforce credentials (team mix)
	Performance on national measure set (i.e. ACO set) as compared to team mix (provider mix, workforce credentials)
	Ratio of healthcare workforce discipline specific workers to specific populations (baseline)
Experience	Using existing CAHPS data for members and patient experience to address issues identified from survey.
Training and Development	Training to improve access via HIT; use of accreditation entities: schools, certifying bodies, employer of workforce accreditation bodies.
	Evaluation of current faculty to teach care in new models and competencies (hours and reteachability)
	Hours of training (clinical/schools) in new delivery systems.
	Core competencies in care of older adults
	Use of training and core competencies (QI only)
Clinical Community and Cross Disciplinary Relationships	Access to services for social issues
	Patient perception of team based care: perception of adequacies of team based care
	Facility use of team based care
	Practice to community resources
Infrastructure	adequacy of workforce).
	Telehealth (behavioral health, geographic shortage area, use for decision making). Distance based measurement (workforce extender).
	Integrated personnel H.I.E. personnel (management of systems); # of health systems on H.I.E.
	E-Approval for prior authorization.
	Patient ability to use after visit data
	True meaningful use of H.I.E.

Members also:

- Identified specific challenges and opportunities in managing the care of the consumer including inter-professional training curriculums and increasing access to health care services through telemedicine
- Discussed the geographic makeup of the workforce and identified a need of a to-be-determined ratio of health worker population to defined geographical area, and
- Suggested that healthcare look to other high functioning systems and incorporate some of their best practices in order to enhance performance and efficiency in cross-cutting areas.

Opportunity for Public Comment

Maureen Dailey from the American Nurses Association noted that the measurement domain of patient safety should be addressed clearly in the framework as part of effectiveness, as well as importance of staffing and skill mix.

Day 2: Wednesday, April 16, 2014

Ms. Lefebvre welcomed the committee and public audience to day two of the meeting and reviewed the previous day's themes. Christine Cassel, President and CEO, NQF, provided opening remarks commending the committee on their important work to identify measure gaps and drive quality

measures in health workforce deployment. Dr. Cassel also discussed the current and future goals of NQF to impact the workforce directly and indirectly with a prominent focus on deployment in terms of care coordination and prevention. She emphasized that NQF's work to date endorsing performance measures and advising HHS on the selection of measures for federal value-based payment and public reporting programs have downstream implications for the workforce; therefore the committee's active engagement is essential to improving the quality of care.

Priorities Round up and Top Recommendations

Ms. Lefebvre facilitated a group activity to prioritize top measure concept recommendations from the small groups. Measure concepts deliberated from the previous days small workgroup exercise were placed on the specific quadrants indicating feasibility and impact, with committee reacting and affirming the placement. The goal was to reach consensus on prioritization of each concept in terms of impact and feasibility. Results of this exercise are as follows:

Quadrants	Measure Concept Placement
High Impact/High Feasibility	o Retention as measured in: discipline area, geographic location, organization, industry, employment vs. unemployment o Community level minority representation of workforce as represented in census data o Level of standard deviation from ideal forecasting at the state level o Infant mortality rate in country or state as compared to workforce credentials (team mix, general health proxy). o Ratio of healthcare workforce discipline specific workers to specific populations baseline o Using existing CAHPS data for members and patient experience to address issues identified from survey. o Evaluation of current faculty to teach care in new models and competencies (hours and re-teachability). o Hours of training (clinical/schools) in new delivery systems. o Core competencies in care of older adults. o Patient perception of adequacies in team based care. o Patient access to ambulatory care. Data source: existing surveys, new surveys of patients crafted to assess adequacy of workforce. o Telehealth (behavioral health, geographic shortage area, use for decision making). Distance based measurement (workforce extender). o Integrated personnel HIE personnel (management of systems, number of systems on HIE). o E-Approval for prior authorization. o True meaningful use of HIE o Mean score on existing standardized tools for patient experience as it pertains to cultural competency.
High Impact/Low Feasibility	o Evaluate the composition of teams that are performing well on national measure sets o Amount of standard deviation from ideal workforce retention and recruitment by discipline (data/evidence based, development needed). o Performance on national measure set (i.e. ACO set) as compared to team mix (provider mix, workforce credentials). o Training to improve access via HIT; use of accreditation entities: schools, certifying bodies, employer of workforce accreditation bodies. o Use of training and core competencies (QI only). o Access to social services for social issues. o Practice to community resources
Low Impact/High Feasibility	None
Low Impact/Low Feasibility	o Facility use of team based care. o Patient ability to use after visit data.

Final Measure Gap Prioritization Exercise

Building on the determinations of the committee regarding the impact and feasibility of the measure concepts, Dr. Gerdes facilitated discussion and a final group activity to reach consensus on prioritizing the concepts. Committee members indicated three levels of preference: high-, medium-, or low priority. Results of this exercise are as follows:

Measure Concept	High Priority	Medium Priority	Low Priority
Evaluate the composition of the composition of teams that are performing well on national measure sets	7 Votes	0 Votes	4 Votes
Using existing CAHPS for member and patient experience (using CAHPS to address specific issues identified from survey)	7 Votes	2 Votes	2 Votes
Ratio of healthcare workforce discipline specific workers to specific populations (baseline)	6 Vote	2 Vote	1 Vote
General health proxy: infant mortality rate in county or state as compared to workforce credentials (team mix)	5 Votes	2 Votes	2 Votes
Performance on national measure set (ACO set) as compared to team mix (provider mix, workforce credentials).	5 Votes	1 Vote	4 Votes
Patient perception: team based care/perception of adequacies of team based care	5 Votes	2 Votes	1 Vote
Retention as measured in: discipline area, geographic location, organization, industry, employment vs. unemployment	4 Votes	4 Votes	1 Vote
Hours of training (in schools) in new delivery systems (all disciplines)	3 Votes	1 Vote	1 Vote
Evaluation of current faculty to teach care in new models and competencies (hours and reteachability)	3 Votes	2 Votes	5 Votes
Patient access to ambulatory care. Data source: existing surveys, new surveys of patients crafted to assess adequacy of workforce.	2 Votes	1 Vote	0 Votes
Community level minority representation compared to minority representation of workforce as represented in census data	1 Vote	2 Votes	1 Vote
Level of standard deviation from ideal forecasting at the state level	1 Vote	0 Votes	7 Votes
Access to services for social issues	1 Vote	1 Vote	1 Vote
Facility use of team based care	1 Vote	1 Vote	2 Votes
Integrated personnel H.I.E. personnel (management of systems); # of health systems on H.I.E.	1 Vote	3 Votes	1 Vote
E-approval for prior authorization	1 Vote	1 Vote	1 Vote
True meaningful use of H.I.E.	1 Vote	3 Votes	4 Votes
Mean score on existing standardized tools for patient experience as it pertains to cultural competency	1 Vote	1 Vote	0 Votes
Amount of standard deviation from ideal workforce retention and recruitment by discipline (data/evidence based development needed)	0 Votes	1 Vote	1 Vote
Training to improve access via HIT	0 Votes	1 Vote	1 Vote
Use of accreditation entities: schools, certifying bodies, employer of workforce/accreditation bodies.	0 Votes	0 Votes	0 Votes
Hours of training (clinical) in new delivery systems (all disciplines)	0 Votes	6 Votes	2 Votes
Core Competencies In Care Of Older Adults	0 Votes	3 Votes	2 Votes
Core competencies in care of older adults: Use of training and core competencies (QI only)	0 Votes	2 Votes	0 Votes
Practice to community resources	0 Votes	3 Votes	3 Votes
Telehealth (behavioral health, geographic shortage area, use for decision making) distance based measurement (workforce extender)	0 Votes	8 Votes	3 Votes
Patient ability to use after visit data	0 Votes	0 Votes	3 Votes

Committee members also highlighted that measure concepts need to address the significant gaps in public health that influence factors of quality of outside of the clinical realm (e.g. smoking, suicide, gun violence). NQF staff then organized the measure concepts by categories including: access and experience, team based care, health proxy, forecasting and composition of workforce, quality improvement, and HIT infrastructure. Committee members also emphasized scope of practice as a key measure concept and discussed potential opportunities for change across all needs areas. They agreed, however, measurement in this area may be very challenging due to the need for culture change and variations in regulation across states. Members also discussed the importance of delivering high quality care but at low cost, noting that many preventive programs are often too costly to implement.

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

All committee members were given the opportunity to voice additional areas of concern for inclusion in the forthcoming report to HHS. The most common recommendations were:

- The focus of measure development should include needs assessment, impact on patient quality of care, and the direct care workforce as well as the community health workforce.
- Developers should focus on measuring the activities most powerful in producing better health, including public health initiatives. They should also focus on measures that improve the overall delivery of care, improve communication across all levels of care, and focus on patient reported outcomes and patient perceptions of the care they receive.
- The definition of 'health care workforce' should be inclusive of paid and unpaid workers, direct care workers, community health workers, and caregivers.
- More data is needed in order to project an accurate need and supply of health care workers to meet the current and future demands of the workforce per capita; current data is incomplete, preventing the development of the right measures.
- Scope of practice needs to be constantly revisited in order to build on useful processes and eliminate wasteful processes; best practices should be observed and modeled.
- There is a difference between training and retraining. Retraining is needed for the current workforce to develop new skills; this will help to maintain an adequate workforce while simultaneously filling high need gap areas.
- Any changes to the health care delivery system must first be person-centered. With that focus, a holistic and adequate health workforce system can be deployed.
- A shorter lag time is needed for leveraging measures, although changes can be incremental, which would allow developers to assess the progress of measures and make appropriate changes as measures mature.
- There is a need for more evidence to be developed in order to support the creation of pipeline measures.

Wrap Up/Next Steps

The meeting concluded with a discussion of next steps. Committee members will receive an updated version of the revised prioritized measurement domains and subdomains for further review and affirmation. The draft report will be made available for NQF Member and public comment in June 2014. During the public comment period, NQF will host a public webinar on June 30, 2014 to engage potential commenters by communicating highlights from three of the draft reports on prioritizing measure gaps. A final version of the committee's recommendations to HHS will be available on August 15, 2014.