Technical Brief

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Measure Criteria for the Agency for Healthcare Research and Quality's National Healthcare Quality and Disparities Report

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Preface

The Agency for Healthcare Research and Quality (AHRQ), through its Evidence-based Practice Centers (EPCs), sponsors the development of evidence reports and technology assessments to assist public- and private-sector organizations in their efforts to improve the quality of healthcare in the United States. The reports and assessments provide organizations with comprehensive, science-based information on common, costly medical conditions and new healthcare technologies and strategies. The EPCs systematically review the relevant scientific literature on topics assigned to them by AHRQ and conduct additional analyses when appropriate prior to developing their reports and assessments.

This EPC evidence report is a Technical Brief. A Technical Brief is a rapid report, typically on an emerging medical technology, strategy or intervention. It provides an overview of key issues related to the intervention—for example, current indications, relevant patient populations and subgroups of interest, outcomes measured, and contextual factors that may affect decisions regarding the intervention. Although Technical Briefs generally focus on interventions for which there are limited published data and too few completed protocol-driven studies to support definitive conclusions, the decision to request a Technical Brief is not solely based on the availability of clinical studies. The goals of the Technical Brief are to provide an early objective description of the state of the science, a potential framework for assessing the applications and implications of the intervention, a summary of ongoing research, and information on future research needs. In particular, through the Technical Brief, AHRQ hopes to gain insight on the appropriate conceptual framework and critical issues that will inform future research.

AHRQ expects that the EPC evidence reports and technology assessments will inform individual health plans, providers, and purchasers as well as the healthcare system as a whole by providing important information to help improve healthcare quality.

If you have comments on this Technical Brief, they may be sent by mail to the Task Order Officer named below at: Agency for Healthcare Research and Quality, 5600 Fishers Lane, Rockville, MD 20857, or by email to epc@ahrq.hhs.gov.

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Key Informants

In designing the study questions, the EPC consulted a panel of Key Informants who represent subject experts and end-users of research. Key Informant input can inform key issues related to the topic of the technical brief. Key Informants are not involved in the analysis of the evidence or the writing of the report. Therefore, in the end, study questions, design, methodological approaches and/or conclusions do not necessarily represent the views of individual Key Informants.

Key Informants must disclose any financial conflicts of interest greater than $5,000 and any other relevant business or professional conflicts of interest. Because of their role as end-users, individuals with potential conflicts may be retained. The TOO and the EPC work to balance, manage, or mitigate any conflicts of interest.

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Peer Reviewers

Prior to publication of the final evidence report, EPCs sought input from independent Peer Reviewers without financial conflicts of interest. However, the conclusions and synthesis of the scientific literature presented in this report do not necessarily represent the views of individual reviewers. AHRQ may also seek comments from other Federal agencies when appropriate.

Peer Reviewers must disclose any financial conflicts of interest greater than $5,000 and any other relevant business or professional conflicts of interest. Because of their unique clinical or content expertise, individuals with potential non-financial conflicts may be retained. The TOO and the EPC work to balance, manage, or mitigate any potential non-financial conflicts of interest identified.

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Structured Abstract

Background and objectives. The objective of the technical brief was to review criteria to prioritize measures for the Agency for Healthcare Research and Quality (AHRQ)'s National Healthcare Quality and Disparities Report (NHQDR). The review aimed to ensure that the criteria align with current focus and priority areas.

Review methods. The technical brief combined input from 11 key informants, comprehensive formal literature review searches in 7 research databases, a detailed review of 37 grey literature sources, and discussions with the AHRQ NHQDR team. We mapped NHQDR criteria to existing alternative approaches documenting similarities and differences and assessed additional criteria to identify areas of potential revisions to the NHQDR.

Findings. Across 8,752 identified records, we selected 103 approaches that document criteria to prioritize quality of care and care disparity measures. Comprehensive tables and figures document the existing approaches, pertinent issues identified in discussions with experts and the literature, suggested changes relevant to the current NHQDR criteria, and the rationale for the proposed changes.

Commonly used criteria to select measures across international approaches include the importance, validity, and feasibility of measures. Identified approaches also included additional criteria such as parsimony, comparability, and acceptability of the measures.

Based on the review of the identified information and the unique role of the NHQDR, we consolidated and revised existing criteria, expanded prior recommendations, and emphasized sensitivity to drivers of health. The final set of proposed criteria to prioritize measures include *Alignment; Usability and acceptability; Compatibility; Impact on disparities and drivers of health; and Balance.*

Conclusion. Many criteria to prioritize quality of care and care disparities measures have been suggested and approaches vary considerably across agencies and organizations and the purpose of measuring care quality and disparities. We propose specific revisions to the NHQDR criteria to better align with current focus and priorities, building on existing criteria and principles.

Contents

1. Introduction

In 1998, the President's Advisory Commission on Consumer Protection and Quality of Care in the Health Care Industry called for a national commitment to improving quality and reducing disparities at every level of the health care system. The Agency for Healthcare Research and Quality (AHRQ) then initiated annual reports to Congress to document national trends, identify gaps in care, and paint a picture of the state of healthcare quality and disparities in healthcare delivery, as required by the Healthcare Research and Quality Act of 1999.[1] Since 2003, AHRQ has published annually the National Healthcare Quality Report and the National Healthcare Disparities Report. In 2014, the two reports were combined to be the National Healthcare Quality and Disparities Report (NHQDR).

The NHQDR presents trends for measures related to healthcare quality priority areas, including access to care, affordable care, care coordination, effective treatment, healthy living, patient safety, and person-centered care.[1] The report provides users with the latest available findings on care quality and access to healthcare stratified by diseases and conditions, as well as disparities related to race and ethnicity, income, health insurance status, age, sex, education, setting of care, and type of care. While the primary audience of the report is Congress, the report is also used by health services researchers, state health officials, organizations implementing quality improvement and disparity elimination programs, advocates for specific health conditions or priority populations, and other interest holders. The report aims to educate and inform readers about health care quality and disparities and is not meant to be used for accountability or accreditation purposes.

The NHQDR documents measures that cover a broad array of healthcare services and settings. The NHQDR uses data from existing datasets to summarize healthcare quality and disparities. The NHQDR does not collect primary data; instead, it relies on data provided by federal and state government operating divisions, departments, and agencies, and other data partners such as the American Hospital Association. Sources contributing to the NHQDR provide different perspectives and insight into the quality of healthcare and current healthcare disparities. Data include patient surveys, provider surveys, administrative data from facilities, and medical records, as well as data from registries, surveillance systems, and population statistics. As Americans receive healthcare services in many different ways and across multiple settings, the NHQDR covers a broad range of services and settings, including ambulatory care, health centers, emergency departments, hospitals, nursing homes, hospices, home health, and others.

A key role of the NHQDR is to align measures from various sources to generate meaningful insights for Congress. For each care area, numerous measures of quality have been proposed. A central question for the NHQDR is which indicators should be selected for the report to provide a valid and meaningful snapshot of care quality and disparities. Measures should reflect the aims and objectives of the NHQDR as well as current priorities and developments in quality of care and disparities measurement. For example, extensive research has been conducted regarding operationalizing and measuring equity in recent years.

Various definitions of health equity, healthcare equity, health disparities, and healthcare disparities exist, but current conceptualizations focus on the conditions under which all persons have the opportunities and resources they need to achieve their optimal health.[2] Health equity as the goal depends on valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historic and current injustices, and avoiding or reducing health

and health care disparities.[3, 4] Disparities can be defined as gaps in the quality of health or the quality of healthcare that mirror differences in socioeconomic and demographic groups (such as socioeconomic status, education level, racial and ethnic background, sexual orientation and identification), disability statuses, or geographic areas,[5, 6] which encompasses various non-medical factors that influence health outcomes, including housing, education, employment, and neighborhood conditions.[7, 8] Health equity and health disparities are intertwined, with health equity being the principle underlying a commitment to reduce disparities in health and its determinants, including social determinants.[9] There has been extensive research on how social determinants of health impact healthcare quality and contribute to disparities in health outcomes. The focus on disparities highlights inherent measurement issues associated with identifying differences in care processes, outcomes, or experiences. There are other important issues to consider, including data availability and quality, the validity and reliability of measurement schemes, the possibility of unforeseen adverse effects on vulnerable populations, and how best to achieve long-term impact and sustainability.

1.1 Objectives of the Technical Brief

This technical brief was commissioned to inform AHRQ's work related to the NHQDR. The last time the criteria to prioritize measures for the NHQDR were reviewed in detail was in 2010, i.e., over a decade ago. The last decade saw many changes in the U.S. healthcare landscape (e.g., a major healthcare reform), the U.S. population health (e.g., the COVID-19 pandemic emphasizing disparities, the opioid crisis), and the U.S. healthcare delivery system (e.g., implementation of electronic health records, expansion of telehealth). The objective of this technical brief was to review the criteria for prioritizing measures to be included in the NHQDR to ensure that the criteria align with current priority areas as well as focus areas of equity and social drivers of health.

1.2 Guiding Questions

Updating the criteria to prioritize measures for the NHQDR is a conceptually challenging undertaking that needs to take many considerations and interest holder perspectives into account. The technical brief addressed the following guiding questions:

GQ1. Which prioritization criteria for healthcare quality measures have been proposed?
- GQ1a. What settings and intended use were the criteria developed for?
- GQ1b. How are the criteria defined and operationalized?
- GQ 1c. In what context have these criteria been used?
- GC1d. How are the criteria similar or different from the current NHQDR criteria?

GQ2. How could the current NHQDR measure selection prioritization criteria be updated?
- GQ2a. What is the operationalized definition of each updated prioritization criteria?
- GQ2b. What type of healthcare quality measures would help the NHQDR's primary audience monitor the effectiveness of health policy levers?

GQ3. How could the new NHDQR measure selection prioritization criteria be applied?

2. Methods

The methods for this technical brief followed the Methods Guide for the Evidence-based Practice Center (EPC) Program.[10] The technical brief followed a detailed published protocol documented on the AHRQ website and we registered the scoping review contributing to the technical brief in the Open Science Framework.[11, 12] This technical brief aimed to answer the guiding questions with information from interviews with key informants, scientific publication, grey literature, and discussions with the NHQDR team. The identified information was used to make recommendations regarding the criteria to prioritize measures for the NHQDR.

2.1 Input from Key Informants

We held key informant calls to elicit input on the guiding questions and our approach to this technical brief. We selected key areas for which we identified representatives: quality of care measurement, disparities measurement, race equity, sex equity, geographic equity, patient safety, health insurance, and digital health services. In addition, we engaged key informants to provide more information on measure prioritization at other federal operating divisions, agencies, and departments, i.e., CMS (Centers of Medicare and Medicaid Services), SAMHSA (Substance Abuse and Mental Health Services), CDC (Centers for Disease Control and Prevention), and VHA (Veterans Health Administration). The selected 11 (4 federal, 7 non-federal) key informants provided information not necessarily (or not yet) captured in the published literature. The specific questions for key informants are documented in Table 1.

Table 1. Key Informant Questions

Topic Area	Questions
Guiding questions	Are we asking the right questions? Are we addressing the most important knowledge gaps?
Current criteria for measures	Which prioritization criteria for quality of care and disparities measures are you familiar with and do you have any recommendations? Can you recommend measures of equity (rather than measuring disparities)?
NHQDR revisions	How should the current NHQDR process be updated? What type of criteria would help the NHQDR's primary audience monitor the effectiveness of health policy levers?
Search and sources	Do you have any comments or additions to the search strategy? Are there additional sources of information and/or data?
Organization and appraisal	The technical brief compares and contrasts approaches from different organizations to prioritize quality of care measures. How can the measure prioritization criteria best be described and compared? How should prioritization criteria approaches be evaluated or appraised?

The key informant interviews followed a semi-structured format. Interviews were conducted as web conferences, and we invited key informants to individual or group interviews as their schedule allowed. Key informants received the protocol of this technical brief and the topic areas for discussions in advance to facilitate meaningful exchange during the call. Interviews were documented during each call in a structured form. The form allowed investigators to review responses across key informants as well as in the context of the overall discussions with the key informant. We reviewed notes in the team and discussed key aspects and recurring themes among the investigator team. Responses were integrated with the identified scientific and grey literature as well as information from discussions with the NHQDR team.

2.2 Published Literature Search

This technical brief is part of a series of products geared towards supporting an update of the NHQDR and we combined searches for measure criteria with searches for quality of care frameworks and other relevant aspects where appropriate.[13]

We searched the databases PubMed (biomedical literature), CINAHL (allied nursing), PsycINFO (psychosocial literature), Social Work Abstract (social work research), the Cochrane Database of Systematic Reviews, and the Campbell Collaboration systematic review in December 2024. Prior to the search for criteria to prioritize quality of care and care disparities measures, we undertook exploratory searches on measuring quality of care to inform the search strategy. The final search strategy is documented in Appendix A. The exploratory searches highlighted the challenge of balancing the search yield and not missing relevant publications. The terminology for quality of care indicators is not standardized and nomenclature varies across clinical fields. The literature searches used a set of general quality of care indicator terms ("Quality Indicators, Health Care"[Mesh]) combined with search terms for selecting, prioritizing, and agreeing on quality of care and disparities measures (e.g., consensus). Searches used controlled vocabulary where applicable as well as text words so as not to miss newer studies that were not fully indexed yet in the databases. We combined searches with a parallel project that aimed to identify frameworks of healthcare quality and disparities.

We also reference-mined existing reviews and background papers and screened included publications to ensure that no relevant approach was missed.[14] In addition, we reviewed all sources with the key informants to ensure that the search was comprehensive. Hand searches focused on identifying information that outlines the criteria that have been suggested for the NHQDR. Literature searches were designed, executed, and documented by the EPC Librarian. Searches were conducted without date restriction.

2.3 Grey Literature Sources

We reviewed the websites of 37 sources, including health services research organizations, funders of research, and agencies charged with improving quality of care or those that address health disparities as outlined in Appendix A. We reviewed the website of U.S. federal operating divisions, departments, and agencies, such as HHS (Department of Health and Human Services), ASPE (Assistant Secretary for Planning and Evaluation), and NIMHD (National Institute of Minority Health and Health Disparities); as well as potentially relevant information on PCORI (Patient-Centered Outcomes Research Institute), ESHPI (AcademyHealth's Evidence-Informed State Health Policy Institute), and NAM (National Academy of Medicine) websites. Sources were selected based on applicability to the U.S. healthcare system, and we followed recommendations of consulted experts, including the key informants, for sources and approaches.

Finally, AHRQ set up a portal for submissions of Supplemental Evidence And Data for Systematic Reviews (SEADs) and published a notice on the Federal Register to encourage SEADs submissions. However, no submissions were received.

2.4. Discussions with AHRQ's NHQDR Team

We sought input from the current NHQDR team regarding:
- The need for information regarding the criteria versus the process for identifying, selecting, and prioritizing measures.

- The importance of content validity for the total measure set; the importance of the big picture, for example, selecting measures across clinical areas or settings, or sampling strategies to ensure content validity of the overall measure set.
- The NHQDR team's positions on the number of measures included in the NHQDR, thoughts on quota, limiting the overall number of measures.
- The importance of the developing paradigm shift from the focus on health (i.e., absence of disease) to the focus on well-being (i.e., wellness and disease prevention) within healthcare. [15] [16]
- The team's position regarding prioritizing outcomes over process measures. Discussions addressed outcome-centered value-based care, as well as the position to prioritize process over outcome measures, given that processes are under the control of the healthcare facility while patient health outcomes are only to an extent.
- The focus on equity in health outcomes versus the focus on equity in healthcare processes (i.e., health equity versus healthcare equity),[17] the difference between the two concepts, and the role of equality in achieving equity (i.e., for high-risk subgroups, there likely need to be compensatory procedures to ensure equity in health outcomes, i.e., not equal but unequal healthcare processes).
- Equity versus disparity: measures of equity being not limited to measures of disparity (the absence of disparities does not necessarily mean equity is achieved; it could be both subgroups not meeting standards).

In addition, we considered input elicited for a parallel technical brief aiming to suggest updates to the framework underpinning the NHQDR. We engaged four representatives from AHRQ involved in the production of the NHQDR and the NHQDR team was present at each monthly update to report the status of the series of evidence review products undertaken to support the NHQDR. Input was sought in discussions and written input for more complex questions. We used the input to better understand the NHQDR production and developments over time and discussed the implication of potential changes to the NHQDR.

2.5 Eligibility Criteria

Based on the outlined sources, we aimed to identify existing criteria to prioritize quality of care and care disparities measures. Table 2 describes the eligibility criteria in a Population, Concept, Context, and Other limiters framework.

2. Methods

Table 2. Criteria for Inclusion/Exclusion of Studies in the Technical Brief

Domain	Inclusion	Exclusion
Population	• Publications that describe criteria to select or prioritize quality of care measures, indicators, criteria, or benchmarks. We accepted the authors' definition of quality of care. Quality indicators may include care processes-related measures (e.g., follow-up post discharge, continuity of care, medication errors), heath services utilization measures (e.g., hospital readmission, emergency department visit), care satisfaction or care experiences (e.g., patient satisfaction, care needs met, trust in care provider), or health outcomes (e.g., mortality, physical functional status, mental functioning, quality of life) used as quality indicators; care disparities may either address differences in provided health services, focus on care services or health outcomes of priority populations (i.e., marginalized groups or people who face greater health obstacles due to race, ethnicity, sex, sexual orientation, income, disability, or geographic location)	• Publications not addressing quality of care, disparities, or drivers of health, or publications suggesting measures only for individual clinical areas or patient populations rather than the healthcare system more generally or healthcare organization-wide criteria
Concept	• Publications that describe a process of developing, selecting, evaluating, prioritizing, or agreeing on measures and that report on the criteria applied to the measures; we accepted selection criteria, information on guiding principles, proposed decision rules, or consensus finding methods related to measure prioritization; publications had to describe an empirical and ongoing or completed process to select measures used to assess care quality of a healthcare delivery organization or healthcare system	• Publications without documented criteria to select, prioritize, or agree on measures, publications stating only the need for quality of care measures, describing only quality of care measures without describing the process of selecting measures, only discussing the importance of selecting measures, or only describing hypothetical steps to select measures
Context	• Healthcare, specifically healthcare delivery organizations and health systems	• Studies in contexts outside of healthcare
Other limiters	• Reports published in English-language journal manuscripts, trial records, and gray literature in the public domain from the outlined sources	• Data reported in abbreviated format (e.g., conference abstracts) and studies not published in English • Systematic reviews were retained for reference mining

We excluded criteria for specific populations such as patients with diabetes, or clinical areas such as diabetes care, because we were interested in systems that were broadly applicable. In addition, we were interested in how approaches achieve balance between different clinical conditions, settings and sites, and populations.

2.6 Review and Synthesis

Literature screening and data abstraction were conducted in an online database designed for systematic reviews (DistillerSR). Literature reviewers screened citations, supported by machine learning to reduce reviewer errors and bias. After an initial screen by a single reviewer, the machine learning algorithm screened all citations again for consistency of decisions to ensure that no likely relevant publications have been missed. All citations that at least one reviewer determined to be potentially relevant to the technical brief were obtained as full text. Full text studies were screened by two independent literature reviewers against the explicit eligibility criteria and disagreements were resolved by consensus.

The data abstraction captured detailed information about the identified process and criteria to prioritize measures. We extracted the criteria together with their definition where reported. We recorded the identification process for potential measures, any eligibility requirement for measures, any interest holder involvement in the prioritization process, consensus finding methods, and procedures used to prioritize measures.[11] To understand how the prioritization

criteria were used, we abstracted the nature of the measures (structure, process, outcomes, patient perception), and the broad system or clinical area for which measures were proposed. We also captured any information pertaining to required feasibility, reliability, and validity of measures (e.g., reviewer agreement on measures, whether the measures had to have been applied empirically, restrictions regarding the procedural effort to obtain measures, evidence of content validity for the measure selection, or the ability to capture care disparities).

Critical appraisal of identified approaches focused on the source (e.g., published by an individual author group or endorsement by a professional organization), interest holder involvement (in the development of the framework), evidence base status (e.g., components based on a systematic review of the literature or local empirical data), the presence of defined population (the framework's target was clearly reported), and evidence of validity testing (e.g., goodness of fit assessed, applied in different contexts) following a critical appraisal form developed for a prior framework review.[18]

Summary tables and figures illustrate the identified data. Throughout, we compared and contrasted identified approaches with the NHQDR criteria to prioritize measures.[19] To determine the frequency of concepts in this analysis, we used labels as used in the identified approach and the NHQDR. For example, we counted 'reliability' as present in the approach if the authors used the term to describe the selection or prioritization criterion. In publications that used different labels, we reviewed the definition of the term and counted the criterion in the analysis if the authors' definition used the term of interest (e.g., a publication stating repeatability with the description pointing to reliability). We did not make assumptions such as when 'scientific soundness' was used, 'reliability' must also have considered, because some authors (but not all) defined scientific soundness to encompass reliability. The synthesis provided a broad overview, followed by a response to the guiding questions of this technical brief.

2.7 Proposed Updates to the NHQDR Measure Criteria

We developed the proposed update iteratively throughout the course of the project. The guiding principle for the work was to account for the unique nature of the NHQDR and its purpose. The starting point for the potential update were the existing criteria to prioritize measures that have been recommended or assumed to be in use for the NHQDR in the past or that were documented in prior published reports.

We critically reviewed all criteria that have been suggested for the NHQDR. We systematically documented issues identified across all information sources for the latest two sets of prioritization criteria formulated for the NHQDR. For the potential update of the criteria we focused on incorporating areas of importance not yet captured in the prior criteria but that are considered important in today's healthcare landscape, in particular equity and social drivers of health. We also reviewed data already currently included in the NHQDR, but that were not yet explicitly addressed in the prioritization criteria for measures. Finally, we considered any new criteria that may be useful to adopt in the future discovered in the consulted sources. Potential new criteria were either suggested by key informants, were identified in the published or grey literature, or came up in discussions with the NHQDR team.

We considered the principles of parsimony and feasibility when suggesting new criteria or when reviewing existing criteria that may benefit from consolidating. Decisions also considered that members of Congress or Congressional staffers are one of the known end users of the report. The criteria to prioritize measures need to align with Congress's interest for this picture of U.S. healthcare quality and need to make the selection and organization of information as useful and

responsive as possible. At the same time, the criteria also have to be feasible for use in practice by the NHQDR team to select measures for the annual reports. Throughout, we put more emphasis on issues that were raised multiple times, either by different key informants or across different information sources. Finally, we aimed to ensure that the proposed prioritization criteria align with current priorities and developments in quality of care and disparities measurement.

We discussed the identified information and conceptual input across the different sources in the project team and engaged the AHRQ NHQDR team in discussions regarding suggested changes.

2.8 Peer Review and Public Commentary

Experts in fields and individuals representing stakeholder and user communities were invited to provide external peer review of this technical brief; AHRQ and an associate editor also provided comments. The draft report was available for public comment (December 17, 2024-January 17, 2025). We addressed all peer reviewer comments and revised the text as appropriate. A disposition of comments document providing a high-level summary of the comments will be posted about three months after the final report is published. No public comments were submitted.

3. Findings

This technical brief drew on multiple sources and the following summarizes the input.

Key informants agreed that we are asking the right questions and provided very informative input regarding recommendations for established criteria to select measures, scientific literature and grey literature or additional sources, the organization and appraisal of approaches, and potential NHQDR revisions. Discussions with the NHQDR team addressed overarching themes regarding the NHQDR as a surveillance tool for the U.S., mechanisms to select and retire measures, as well as specific criteria to select measures (e.g., applicability of measures to general vs select populations). All the above sources of input recommended material that should be reviewed for eligibility in the technical brief. The flow diagram (Figure 1) shows the disposition of identified sources of information.

Figure 1. Flow diagram
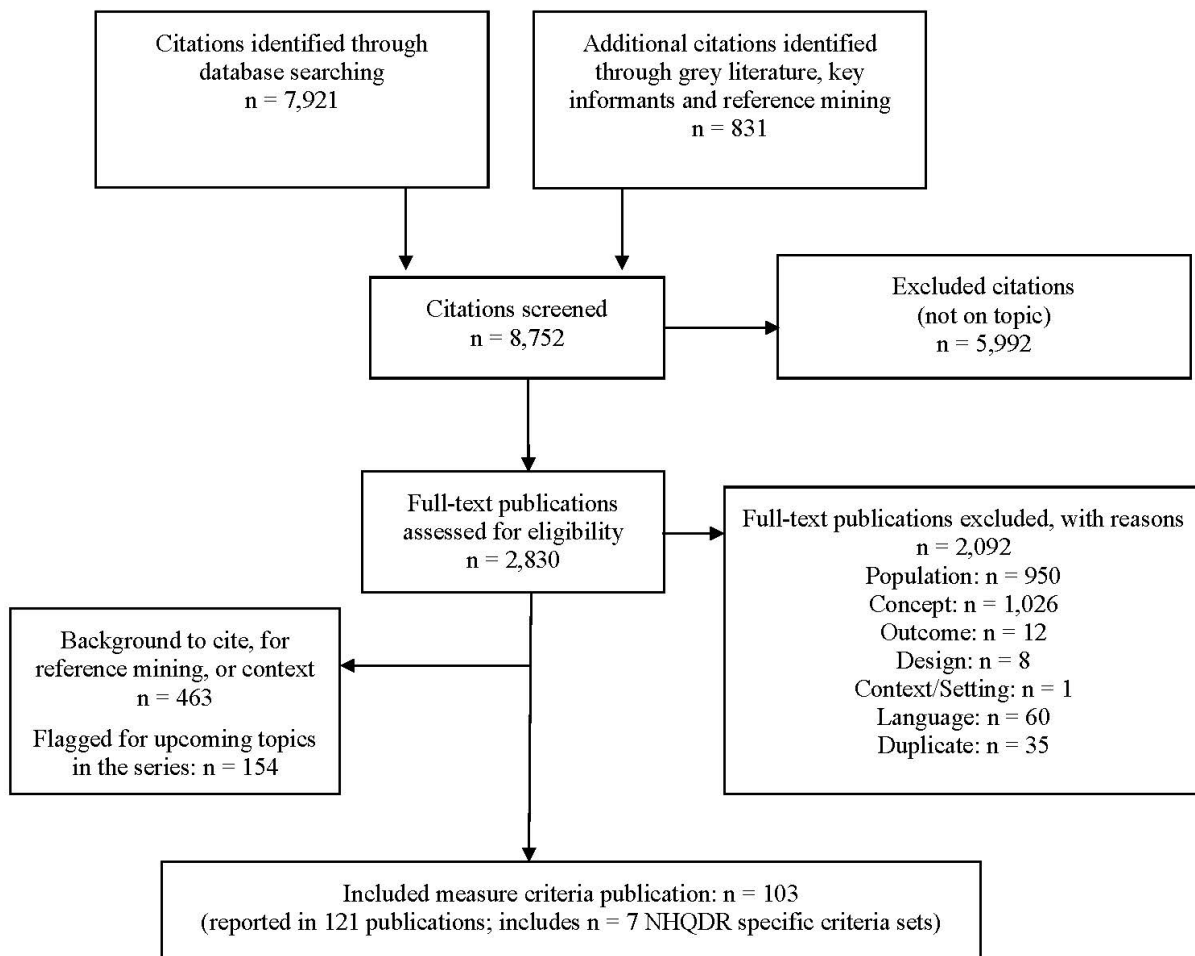
Across sources, we reviewed 8,752 records, 2,830 publications were reviewed as full text, and we included 103 approaches documenting a set of criteria to prioritize quality of care and disparities measures published in 121 publications (the criteria were sometimes reported in more than one publication).[19-139] This included 7 publications that documented or recommended criteria for the NHQDR. In addition, 463 background articles provided additional information

relevant to the project or were reference-mined for potential additional frameworks. The list of included, background, and excluded studies are shown in Appendix B. The reasons for exclusion are also reported in the appendix.

The remainder of the report is organized by the guiding questions.

Main Findings for Guiding Question 1: Which prioritization criteria for healthcare quality measures have been proposed?

We identified 7 recommendations or documentation of criteria developed for the NHQDR or its predecessors[19, 62, 92, 130-133] and 96 other relevant approaches that have formulated criteria to prioritizing measures to assess quality of care and care disparities.[21-23, 26-46, 48-53, 55, 58-60, 63-66, 68-78, 80-82, 84-88, 90, 91, 93-98, 100, 102, 104, 106-122, 125-129, 134-139] The earliest included approaches were from the 1990s. The criteria sets ranged from a description of a general guiding principle to approaches that formulated several dozens of criteria; the majority included between three and six criteria. The format varied, with some approaches providing detailed explanations for each criterion. Several differentiated between primary and secondary criteria or principles. The approaches and the proposed criteria are summarized in detail in the evidence table in Appendix C.

Table 3 presents criteria for measures (in chronological order) that have been formulated specifically for the National Healthcare Disparities Report, the National Healthcare Quality Report, or the NHQDR that combines both original reports to date.

Table 3. NHQDR Criteria and Principles for Prioritizing Measures Suggested to Date

Publishing Source Year Content	Report and Location of Criteria	Criteria and Principles
IOM 2001 Recommendation	Recommendations for Measure Selection for the National Healthcare Quality Report and National Healthcare Disparities Report Box 3.1 Desirable characteristics of measures for the National Health Care Quality Report	1. **Importance** of what is being measured • *Impact on health.* What is the impact on health associated with this problem? • *Meaningfulness.* Are policy makers and consumers concerned about this area? • *Susceptibility to being influenced by the health care system.* Can the health care system meaningfully address this aspect or problem? 2. **Scientific soundness** of the measure • *Validity.* Does the measure actually measure what it is intended to measure? • *Reliability.* Does the measure provide stable results across various populations and circumstances? • *Explicitness of the evidence base.* Is there scientific evidence available to support the measure? 3. **Feasibility** of using the measure • *Existence of prototypes.* Is the measure in use? • *Availability of required data across the system.* Can information needed for the measure be collected in the scale and time frame required? • *Cost or burden of measurement.* How much will it cost to collect the data needed for the measure? • *Capacity of data and measure to support subgroup analyses.* Can the measure be used to compare different groups of the population?
IOM 2002 Recommendation	Guidance for the National Healthcare Disparities Report 4–8. Choosing among potential measures	Core measures should continue to be used. New measures should fulfil the following criteria: 1. They should represent issues that affect all populations, but that affect minority populations in an important way. For disease-specific measures, priority should be given to those conditions that were the focus of the 1998 Federal Initiative to Eliminate Racial and Ethnic Disparities in Health. 2. They should cover the lifespan. 3. They should capture disparities that are known to exist. 4. They should add important information beyond core measures. 5. There is a strong likelihood that the health of minority populations would improve if the focus of measurement were addressed. It is also possible that addressing some foci

3. Findings

Publishing Source Year Content	Report and Location of Criteria	Criteria and Principles
		would improve health for all populations without decreasing disparities. Because the primary aim is improved health, measures should not be discarded for this reason. 6. They are particularly important for specific populations, even if they are less salient to Whites. 7. They fill gaps in the quality framework, including the continuum of care, attributes of quality, or care over the lifespan. 8. They reflect patient-centered or community-centered aspects of access. 9. They incorporate an expanded definition of health. This is particularly important for mental health since it is an important co-morbidity for chronic diseases such as diabetes and etiologic in much care-seeking New measures should be selected from priority measures that do not involve substantial development.
AHRQ 2003 Documentation	National Healthcare Quality Report Executive summary	• **Clinical importance** • **Scientific soundness** • **Feasibility** All measurement and reporting efforts must strike a balance among the tensions inherent in meeting all 3 criteria. Whenever possible, measures use assessments of performance that are consistent with current science and supported by professional consensus.
AHRQ 2003 Documentation	National Healthcare Disparities Report Methods; Selection of Measures	All measures included in the 2003 NHQR 2 key principles, used whenever possible: • Measures developed through consensus processes, whereby experts convene and deliberate with the goal of producing high quality measures • Measures consistent with Federal guidelines and publications
AHRQ 2004 Documentation	National Healthcare Quality Report National Healthcare Disparities Report	• **Clinical importance** • **Scientific soundness** • **Feasibility** • **Recency of data** – Measures with newer data were favored • **Proximity to care -** Process measures were favored over outcome measures • **Clinical significance** – Measures with greater clinical significance were favored • **Methodological soundness** – Measures with fewer methodological caveats were favored • **Prevalence** – Measures affecting more people were favored over measures affecting fewer people
AHRQ 2005 Documentation	National Healthcare Disparities Report Table 1.1. Criteria for selecting core report measures National Healthcare Quality Report Table 1.1 Criteria for selecting core report measures	**Primary Criteria** • Importance/clinical significance/prevalence • Reliability of data • Ability to track multiple disparities groups at multiple levels/number of comparisons possible • Sensitivity to change (evidence-based process measures favored over outcomes) • Ease of interpretation and understanding/methodological simplicity • High utility for directing public policy **Secondary Criteria** • Applicability to the general U.S. population • Availability of data regularly and recently • Ability to link to established indicator sets (i.e., Healthy People 2010 objectives) • Ability to support multivariate modeling **Balancing criteria across core report measures** • Balance across health conditions • Balance across sites of care • Inclusion of at least some State data • Inclusion of at least some multivariate models
IOM 2010 Assumed criteria	Future Directions for the National Healthcare Quality and Disparities Reports Box 4-2 AHRQ's current criteria and principles for prioritizing measures	**Primary Criteria** 1. **Importance** • impact on health (e.g., clinical significance, prevalence); • meaningfulness; and • susceptibility to being influenced by the health system (e.g., high utility for directing public policy, and sensitive to change). 2. **Scientific Soundness** (assumed because AHRQ only uses consensus-based endorsed measures) 3. **Feasibility**

3. Findings

Publishing Source Year Content	Report and Location of Criteria	Criteria and Principles
		• capacity of data and measure for subgroup analysis (e.g., the ability to track multiple groups and at multiple levels so a number of comparisons are possible); • cost or burden of measurement; • availability of required data for national and subgroup analysis; and • measure prototype in use. 4. **Usability:** easy to interpret and understand (methodological simplicity) 5. **Type of Measure:** evidence-based health care process measures favored over health outcome measures because most outcome measures were too distal to an identified intervention **Secondary Criteria** • applicable to general population rather than unique to select population • data available regularly/data available recently • linkable to established indicator sets (i.e., Healthy People 2010 targets) • data source supports multivariate modeling (e.g., socioeconomic status, race, and ethnicity) **Balancing Principles** • balance across health conditions • balance across sites of care • at least some state data • at least some multivariate models

IOM
2010
Recommendation
	Future Directions for the National Healthcare Quality and Disparities Reports
	
	Figure 4-2 The Future Directions committee's proposed decision-making process for selecting performance measures for the NHQR and NHDR and identifying measure and data needs
		Measures identified in environmental scan for importance
		• Criterion A: **improvability** (evidence that improvement can be made)
		• Criterion B: **sound measure available** (scientifically sound measures have been developed to assess this area)
		• Criterion C: **applicability to national priorities** (measures progress in at least one of the national priority areas for improving the quality of health care and eliminating disparities)
		• Plus:
		  o Criterion D: **value** (measure has the potential to increase health care value by narrowing a defined quality gap, e.g., health outcome for resource investment; degree of clinically preventable burden)
		  o or Criterion E: **population equity** (measure documents significant inequities in care by race, ethnicity, language need, or socioeconomic status)
		  o or Criterion F: **geographic and health systems equity** (measure documents geographic or health system variation in performance)
		Data Availability: An appropriate national data source exist that would support assessment of performance overall as well as among disparity populations

IOM 2010 Recommendation	Future Directions for the National Healthcare Quality and Disparities Reports Appendix F	• Quantified population impact or value of efforts to improve quality and to reduce disparities

Notes: AHRQ Agency for Healthcare Research and Quality, IOM Institute of Medicine (now National Academy of Medicine)

The table includes recommendations for, documentation of, and assumptions about the NHQDR or its predecessor reports. The first recommendations for the reports were published in 2001. Further recommendations for the National Healthcare Disparities Report were published in 2002. The 2003, 2004, and 2005 National Healthcare Disparities Report and the National Healthcare Quality Report (i.e., the first published reports) included detailed descriptions of the criteria used to select measures. The IOM report entitled *Future Directions for the National Healthcare Quality and Disparities Reports* included presumed criteria of the procedure used to date and two sets of recommendations. The table documents applied criteria as well as recommendations for changes to the criteria that have been published in the last 20 years.

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Changes over time reflect the merging of the two reports, refined procedures, and likely also changing priorities within AHRQ.

Criteria to prioritize quality of care and care disparities measures for U.S. initiatives other than specifically developed for the NHQDR are documented Table 4. The table is restricted to those that have been published since the first publication of the National Healthcare Quality Report and the National Healthcare Disparities Report in 2003 and that address the U.S. healthcare system. The complete list of identified international approaches and proposed criteria is documented in Appendix C.

Table 4. Criteria to Prioritize Measures in U.S. Settings Identified in the Literature

Source Year	Criteria
Institute of Medicine, 2005[63]	Scientifically sound Feasibility Importance Alignment Comprehensiveness
Schoen, 2006[118]	Making a positive difference for the nation Data currently exists to track and compare performance over time
Riehle, 2007[114]	Target improvement in the health of populations Precisely defined and specified Reliable Valid Easily interpreted by users Risk-adjusted or stratified Under provider control Have publicly available measure constructs Useful in the accreditation process Rely on accessible data and low-cost data collection efforts In addition:[140] Clinically important Relevant across organizations Feasibility
Kmetik, 2007[68]	1. The topic area is an area designated as high impact (by the IOM, NPP, etc.) 2. The topic is a gap area or an area with high variation in care 3. The topic has an adequate evidence base If the above three criteria are met, evaluate whether the topic under consideration is likely to generate measures in the following four areas, which are termed "high value:" care coordination, patient safety, appropriateness/overuse, and quality improvement collaboratives
Mattke, 2007[82]	Relevance/importance Scientific soundness Feasibility, including measures specifications Usability/actionability
National Quality Forum, 2009[100]	Principle 1: Efficiency measurement is multidimensional Principle 2: The choice of measures to inform judgments on efficiency should include consideration of potential leverage Principle 3: Measures used to inform judgments on efficiency should promote shared accountability across providers and should be assigned to the smallest unit of accountability as technically feasible Principle 4: Measures used to inform judgments on efficiency should respond to the need to harmonize measurement across settings of care Principle 5: Measures to inform judgments on efficiency should be used for benchmarking Principle 6: Public reporting of measures of efficiency should be meaningful and understandable to consumers and entities accountable for their care Principle 7: Inappropriate care cannot be efficient Principle 8: The measurement framework should achieve its intended purpose and should be monitored for unintended consequences Principle 9: Measures to inform judgments on efficiency should be an integral part of a continuous learning system

3. Findings

Source Year	Criteria
AHRQ, 2011[42]	Importance Scientific acceptability Usability Feasibility
National Quality Forum, 2012[98]	First-tier criteria: 1. Prevalence 2. Quality impact 3. Disparities quality gap Second-tier criteria: 1. Care with a high degree of discretion 2. Communication-sensitive services 3. Social-determinant dependent
Fisher, 2013[52]	Related to mental health and/or substance use Precisely defined at the numerator and denominator level, contain information about data sources, and measure quality (as defined by the six US Institute of Medicine domains of effectiveness, efficiency, equitability, safety, timeliness and patient and/or community centered) National- or regional- level focus, or otherwise be used to assess the performance among organizations or providers
Casey, 2013[41]	Volume of the condition(s) addressed by the measure in critical access hospitals Internal usefulness for quality improvement External usefulness for public reporting and payment reform
Committee on Quality Measures for the Healthy People Leading Health Indicators, 2013[44]	Impact (importance) Improvability Scientifically sound measure Geographic, temporal, and population coverage Data availability
Meltzer, 2014[87]	Impact on population health (improve the length and quality of life of the U.S. population)
Remington, 2015[112]	Reflect important aspects of population health that can be improved Availability and reliability of indicators at the county level throughout the nation Ability for conditions underlying a measure to be modified through community action Valid, reliable, recognized, and used by others Available at low or no cost Recently and regularly updated Feedback from a panel of technical experts Alignment with America's Health Rankings' indicators Fewer measures are better than more
National Health Center for Statistics, 2018[94]	Evidence-based National importance: Direct impact or influence on health National importance: Broad and comprehensive applicability National importance: Substantial burden National importance: National (not just federal) public health priority National importance: Summary assessment Health equity and disparities

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Source Year	Criteria
AHRQ, 2018[22]	1. Must address some aspect(s) of healthcare delivery or population health that can be classified into one of the NQMC domains 2. Must be in current use or have been pilot tested within the last 3 years and must be the most recent version if the measure has been revised; a measure is in current use if at least one healthcare organization has used the measure to evaluate or report on quality of care within the previous 3 years 3. The submitter must provide English-language documentation that is available upon request in print or electronic format that includes at least each of the four following items: rationale for the measure; description of the denominator and numerator of the measure; data source(s) for the measure; and documentation of evidence supporting the measure and the criterion of quality is required for Quality Measures, and for the quality component of Efficiency Measures 4. At least one of the following criteria must be satisfied with specific information attached in each case (evidence from peer-reviewed literature is preferred): the measure has been cited in one or more reported in a National Library of Medicine indexed, peer-reviewed journal, applying or evaluating the measure's properties; the submitter provides documented evidence evaluating the reliability and validity of the measure; or the measure has been developed, adopted, adapted, or endorsed by an organization that promotes rigorous development and use of measurement in health care - such an organization may be at the international, national, regional, state or local levels
Hatef, 2018[59]	Population/community focused Importance/applicability Development of a balanced score card of population health Overall practicality and strategic value Data feasibility/supports and expands digital infrastructure Scientific evidence/measures attributes
MacLean, 2018[77]	1. Importance: meaningful clinical impact, High impact, Performance gap 2. Appropriate care: Overuse, Underuse, Time interval, 3. Clinical evidence base: Source, Evidence 4. Measure specifications: Clarity--numerator and denominator clearly defined, Clarity--all components necessary to implement measure clearly defined, Validity, Reliability, Risk adjustment 5. Measure feasibility and applicability: Attribution, Physician's control, Usability, Burden
National Association of County and City Health Officials, 2018[93]	Relevance Importance Clarity Feasibility Uniqueness Manipulability Program influence Longevity
National Academies of Sciences, Engineering, and Medicine, 2019[91]	1. Measurable 2. Current baseline data 3. National importance 3a. Direct impact or influence 3b. Broad and comprehensive applicability 3c. Substantial burden 3d. National (not just federal) public health priority 4. Evidence-base 5. Health equity and disparities
National Health Center for Statistics, 2018[94]	Evidence-based National importance: Direct impact or influence on health National importance: Broad and comprehensive applicability National importance: Substantial burden National importance: National (not just federal) public health priority National importance: Summary assessment Health equity and disparities
Barton, 2020[29]	Relevance Scientific soundness Feasibility

3. Findings

Source Year	Criteria
CMS, 2022[43]	Physician Quality Reporting Initiative: Satisfy statutory requirements for selection Are functional Increase opportunities for eligible professionals to participate in the program or apply to an area without applicable measures Align with other CMS program health care goals Support CMS priorities Address various aspects of clinical care, including process, outcome, structure or patient experience Reporting Hospital Quality Data for Annual Payment Update: Satisfying statutory requirements Expand measures beyond process measures, to measures of outcome, patient perspectives, and efficiency Expand the scope of hospital services to which the measures apply Consider the burden on hospitals Harmonize the measures with other CMS quality programs Weigh the relevance and utility of the measures compared to the burden on hospitals Use measures that are based on currently reported data (i.e., to clinical data registries or all-payer claims databases) or that do not require chart abstraction
Batelle, 2023[30]	Pre-Rulemaking Measure Review: Meaningfulness Appropriateness of scale Time to value realization Measure Set Review: Impact Clinician data streams Patient journey
National Quality Forum, 2023[97]	Importance to measure and report Scientific acceptability of measure properties Feasibility Usability and use Related and competing measures Linked to gains in quality and health outcomes[141]
NQF, 2024[129]	Important to measure and report Scientifically acceptable Usable and relevant Feasible to collect

Our literature review had cast a wide net and the table includes criteria exclusively used to prioritize measures for quality of healthcare, and approaches that are likely only, or at least in part, applicable to population health considerations (i.e., are broader than healthcare). As shown, the style of the criteria varied. While most publications provided labels for the criteria such as *scientific soundness*, some publications provided a narrative of the prioritization process. The number of suggested criteria varied greatly, ranging from one to two criteria to complex systems of criteria that need to be considered before measures can be adopted.

3.1.1 Findings for Guiding Question 1a: What settings and intended use were the criteria developed for?

Published approaches were developed in Australia, Belgium, Canada, China, Denmark, France, Germany, Greece, Iran, Ireland, Korea, Malaysia, the Netherlands, New Zealand, Portugal, Saudia Arabia, Switzerland, the United Kingdom, and the U.S. Others addressed larger regions, in particular Europe and Organization for Economic Cooperation and Development (OECD).

Identified measure criteria were intended for healthcare quality for the healthcare delivery sector in general, population and/ or public health, or specific service types such as inpatient care and primary care. The purpose of the measures included health policy and reporting, community-

based health care quality, and health system performance. Hence, some approaches were broader than the purview of the NHQDR, others narrower, and for others, there was insufficient information to determine the overlap of the scope with the NHQDR's aim and objectives. Furthermore, approaches varied in whether they were developed for systems that provided accountability (i.e., assessing the performance) or served only a descriptive function (e.g., surveillance).

3.1.2 Findings for Guiding Question 1b: How are the criteria defined and operationalized?

For all identified approaches, we abstracted the criteria to prioritize measures as well as the definition or description of the individual criterion as documented in Appendix C. Documentation of the operationalization of the criteria was limited, with many approaches not providing any definition or detailed description. In addition, agencies may have used the same terminology, but defined terms differently with regard to the meaning as well as the conceptual scope of the criterion. Throughout, we abstracted the exact terms used and any definition or description of the term and the following provides definitions and operationalizations organized by NHQDR criteria (starting with the latest recommendation).

The latest recommendations for the NHQDR published in 2010 suggested to use the criterion *improvability* (Criterion A) to select measures.[19] It was defined as evidence that improvements can be made. Of note, susceptibility to being influenced by the healthcare system was part of a criterion named *importance* that had been used before these recommendations were published. Our literature reviewed showed that other approaches use the term as well, for example defined as the extent of the gap between current practice and evidence-based best practice and likelihood that the gap can be closed,[44] or the possibility of interventions to improve the quality indicators.[113] Other approaches referred to the concept as *sensitivity to change* (the extent to which the indicator has the ability to detect changes in the unit of measurement).[121] Related, the criterion *actionability* was mentioned in multiple approaches, but with different definitions. It has been defined as processes or outcomes of care that could be directly affected by healthcare policy or healthcare delivery system interventions[127] or it was defined similar to the NHQDR concept of improvability,[137] respectively.

The recommendation also included the criterion *sound measure available* (Criterion B). It referred to whether scientifically sound measures have been developed to assess the area.[19] If yes, the measure should be included in the NHQDR and if not, it should be considered as an area for measure development. The criterion *feasibility* was included in earlier conceptualizations of the NHQDR.[142] Feasibility is a multi-component concept that can include the existence of a prototype in use, availability of required data points for national and subgroup analyses, cost or burden of measurement, and capacity of data and measure to support subgroup analyses. A recent National Quality Forum (NQF) publication defined feasibility as the extent to which the specifications, including measure logic, required data that are readily available or could be captured without undue burden and can be implemented for performance measurement.[97]

Further, the recommendations included *applicability to national priorities* (Criterion C), defined as the indicator measures progress in at least one of the national priority areas for improving the quality of healthcare and eliminating disparities.[19] Similarly, an aspect that key informants brought up repeatedly was *alignment*. This was also reflected in the literature. For example, a publication documenting a revision of the healthcare system in Saudi Arabia stated

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that upon defining the frameworks' subdomains, a mapping exercise was conducted to align the indicators with their relevant subdomain, and indicators which were not aligned with the subdomains were removed from the indicator pool.[23]

The recommendations also included three further criteria for measures, of which at least one of them had to be met in order to be included in the NHQDR (*value*, *population equity*, and/or *geographic and health systems equity*). All have been discussed extensively in the literature and in key informant discussions for this work. The concept of *value* (Criterion D) was defined as the potential to increase healthcare value by narrowing a defined quality gap (health outcome for resource investment; degree of clinical preventable burden).[19] The criterion was also included in other published criteria sets, but the definitions varied greatly. In a primary care performance application for Ontario, one of the criteria for measures stated that the information is valuable to have on a regular basis for one or more purposes (e.g., service planning, management or quality improvement) at the practice and/or system (community, regional or provincial) levels.[55] A publication outlining the health system performance of New Zealand incorporated value as meaning best value for public health system resources, citing Berwick's triple aim.[26, 143]

Population equity (Criterion E) was defined as whether the measure documents significant inequities in care by race, ethnicity, language need, or socioeconomic status, while the criterion *geographic and health systems equity* was met when the measure can document geographic or health system variation in performance.[19] Multiple publications described a similar criterion related to equity or disparities in populations. Definitions varied and included a gap in quality of care between disadvantaged populations and groups with the highest quality of that measure,[63] and requiring that indicators were valid and reliable for the general population as well as diverse populations (i.e., Aboriginal and Torres Strait Islander peoples, rural/urban, socioeconomic etc.).[96] Similarly, multiple criteria sets included geographic equity, matching Criterion F (geographic and health systems equity, but the operationalizations varied from ensuring geographic coverage in a Healthy People publication[44] to indicators having local importance[107] in the New Zealand performance publication. Some of the approaches determined finding measures that are dependent on social determinants,[98] or that are addressing health equity and disparities by having population data broken down by relevant characteristics such as race, family income, and geographic location

In addition to the recommendations of Criterion A to F, the 2010 NHQDR report also provided a detailed description of which criteria were used for the NHQDR to date. For many years, the National Healthcare Quality Report, the National Healthcare Disparities Report, and the NHQDR used *importance* as a criterion to select measures. And although not an explicit criterion, the latest comprehensive recommendations for the NHQDR in the 2010 IOM report included importance as a prerequisite, because measures considered for inclusion in the NHQDR are identified through an environmental scan. Importance is conceptualized as likely to be high-impact based on potential population impact, high cost, variation in quality, low performance levels, or existing disparities.[142] Many of the identified approaches used importance as part of the criteria to select measures. However, across approaches, the dimension meant different things. An NQF publication defined importance as keeping the focus on priority areas where the evidence is highest that measurement can have a positive impact on healthcare quality.[129] A publication focused on documenting primary care quality in Canada defined importance as that the measures provide information that can be used to inform policy decisions or change the behavior of health service providers, in addition to impact on healthcare.[74]

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Scientific soundness used to be a criterion in the National Healthcare Quality Report and the National Healthcare Disparities Report. However, in the latest set of recommendations published in 2010, scientific soundness is described as assumed because the NHQDR utilizes reliable data collected as part of federal and state governments' internal monitoring/surveillance functions. Many published measure selection approaches include scientific soundness or components such as validity and reliability. Some approaches, such as the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), define scientific soundness from an evidence-based approach, meaning based on best available evidence, process or structural measures are linked to outcomes, and being described as 'accurate- reliable-valid.'[29]

The 2010 IOM report assumed that the NHQDR measures were to that date selected based on *usability*, defined as the measure needing to be easy to interpret and to understand (methodological simplicity). Other approaches in the literature define usability more comprehensively. For example, NQF[97] defined it as accountability and transparency; improvement; the benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations.

Based on the 2010 IOM report, the NHQDR favored evidence-based healthcare process measures over health outcome measures as part of the *type of measure* criterion up to 2010.[142] The term refers to Donabedian's structure, process, outcome model of quality of care measures;[144] where structure refers to the facility, equipment, and personnel capabilities, availability, and expertise; process refers to operations of care such as the number of tests ordered; while outcomes refer to patient health outcomes defined as states or conditions of individuals and populations attributed or attributable to antecedent health care.[145] With few exceptions,[107] most identified criteria sets to prioritize measures do not include this criterion.

The four secondary criteria that were assumed to guide the NHQDR until the 2010 recommendations were more descriptive in nature.[142] The criterion *applicable to general population* required that the measure is applicable to the general population rather than to select populations. The criterion *data available regularly/data available recently* was not further described. The criterion *linkable to established indicator sets* listed Healthy People 2010 targets as an example. The most complex criterion, *data source supports multivariate modeling*, referred to the ability to analyze subgroups, for example based on socioeconomic status, race, and ethnicity. To produce subgroup analyses, in particular to identify disparities, the analyst needs to have access to confounders and the NHQDR can only report on groups that are tracked in the dataset (e.g., to analyze disparities based on demographic variables, the demographic variables need to be available in the report).

The National Healthcare Quality Report and National Healthcare Disparities Report were assumed to have *balancing principles*, defined as balance across health conditions, across care sites, some state data and some multivariate models.[19] Several key informants and identified published approaches stressed the importance of a curation process across content areas. Published approaches reported different aspects of curation, i.e., to avoid redundancy in measures, to consider measure collection and evaluation burden, and to emphasize parsimony. The NQF emphasizes that measure specifications are either harmonized for related measures (select a valid or efficient way to measure) or the differences in specifications are justified (multiple measures are justified).[97]

3.1.3 Findings for Guiding Question 1c: In what context have these criteria been used?

Approaches published in the international literature varied widely and included several national healthcare performance measurement projects as well as indicator sets for a single healthcare delivery organization. From the identified publications it was not always clear whether criteria had already been applied or whether the criteria were a proposed approach for future measure prioritization. Where stated, the application context varied from criteria used for measure endorsement by the NQF[129, 146] criteria for indicators for quality of care for a hospital, criteria to use in clinical practice guidelines, and criteria for reporting on public health.

3.1.4 Findings for Guiding Question 1d: How are the criteria similar or different from the current NHQDR measure criteria?

We tracked the frequency of two prominent applied and recommended criteria sets for the NHQDR outlined in Table 3 across all approaches and identified criteria sets. We also tracked the frequency of the basic measurement criteria *objectivity* (evidence that the measure is applied and interpreted the same way by two different raters), *reliability* (evidence that the measure is stable and consistent), and *validity* (evidence that the measure assesses what it is supposed to measure). Finally, we tracked which approach included additional criteria to prioritize measures (category *other*). Figure 2 presents the frequency of the individual criteria.

Figure 2. Frequency (count) of NHQDR Criteria and Basic Measurement Criteria Found Across Other Approaches
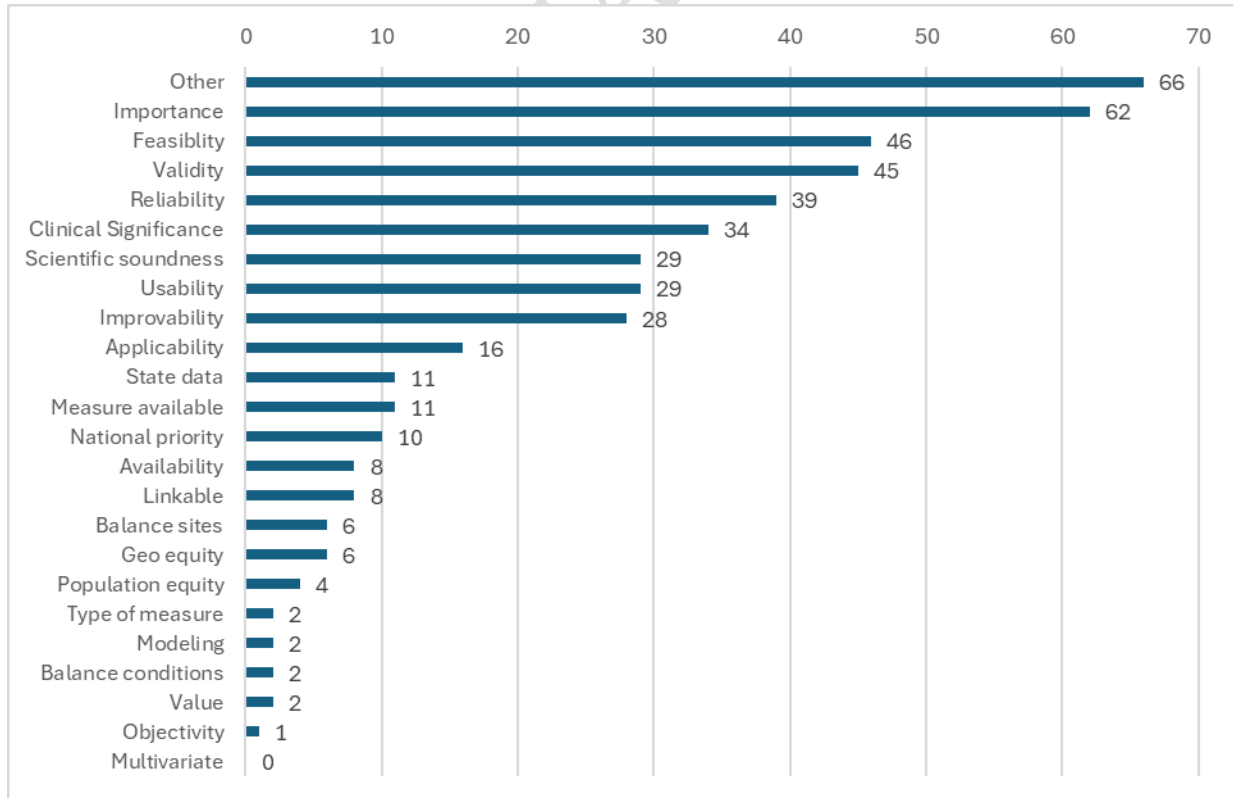
3. Findings

As shown in the figure, the criterion *importance* was most frequently used, followed in frequency by the criterion *validity*, and *feasibility*. Of the Criteria A to F recommended for the NHQDR in 2010, *improvability* (Criterion A) was most commonly reported in other approaches, while *value* (Criterion D) was least commonly represented in other approaches. In terms of prior criteria, *importance* (see primary criterion in Table 3) was commonly represented, while the criteria around *multivariate data* (see secondary criteria in Table 3) and *multivariate models* (see balancing principles in Table 3) was not included in other approaches. Across all criteria, primary criteria that presumably had been used in the NHQDR to 2010 (*importance, scientific soundness, feasibility, usability, type of measure*) were more frequent in other approaches than the three new main recommended criteria (i.e., *improvability, sound measure available,* and *applicability to national priorities*). The shown ranking should be interpreted with some caution as some of the criteria are broader than others, for example, *scientific soundness* was defined as including reliability and validity in the first recommendations for the National Healthcare Quality and the National Healthcare Disparities Reports.[62]

Appendix D provides a matrix of criteria in each identified approach mapped to the NHQDR measurement criteria (excluding NHQDR publications). The table shows which approaches are conceptually most similar to the NHQDR due to overlapping criteria domains. Across criteria that have been proposed for the NHQDR, most overlap was identified for a New Zealand initiative to develop performance indicators for primary care,[107] an Australian approach to prioritizing quality indicator development across healthcare systems,[50] a comprehensive review and international expert consensus process for criteria for the improvement of health care quality,[60] and an early Australian National Health Performance Committee approach.[96]

Differences between the NHQDR and other published approaches are also documented in detail in the evidence table in Appendix C. Almost all approaches included other aspects that are not part of the NHQDR criteria to prioritize measures.

The *acceptability* of the measure was suggested as a criterion in multiple other publications. The conceptualization included the collection of information for criteria based review is acceptable to those patients whose care is being reviewed[60] or those that are being assessed,[121] explicitly requiring that the purpose for the introduction of the indicator is stated,[107] that the assessment purpose is considered,[117] or more generally that interest holders accept the measure, or that the measure is based on agreed upon benchmarks or guidelines.[38] Some approaches required that the measure is simple and communicable[35] or interpretable.[32]

Multiple approaches stressed the importance of *alignment*. This included alignment with an underlying framework,[23, 117] relevant to established health goals[38] or program goals,[43] and links to the Institute for Healthcare Improvement's triple aim.[55]

Multiple approaches mentioned *burden* of measurement. This was defined as the cost of measurement;[27] administrative burden;[27, 60] the collection of information required for criteria based review minimizes demands on staff, availability of data at low or no cost;[112] data collection being feasible and burden is acceptable;[77] and the need to weigh the relevance and utility of the measures compared to the burden on the healthcare facility.[43]

The *clinical significance* was also subject of many approaches. The specific description of the criterion was reported as to include measures that had to be clinically useful to be selected;[71] address frequent condition,[41] focus on disease pathways that have most impact on the health of the population and the health system;[76] in the absence of outcome measures, process or structure indicator need a direct or proven relationship with an outcome;[33] the process is linked to gains in health outcomes;[97] improves quality, safety, or experience of care;[26] or addresses the right aspect

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of care, in the right setting, and at the right point in a patient's journey to maximize the desired outcome,[30] respectively. Other approaches defined significance as a focuses on proven drivers of health system outcomes,[76] social determinant-dependent,[98] or a gap area or area with high variation in care.[68]

Multiple approaches made the need for *comparability* explicit beyond linking to specific datasets such as Healthy People. This included complying with national processes of data definitions,[96] that the data can be harmonized with other relevant measures,[43] enabling national or international comparisons,[40, 118] national or international benchmarking,[76] and allowing to track performance over time.[118]

Several approaches explicitly restricted to measures that are under the *control* of the healthcare system or that are potentially actionable. This included requirements for measures to be under the control of healthcare providers,[85, 114] performance is measured for interventions that are under the influence of the physician being assessed,[77] measures that could be used for quality improvement,[41, 68] measures are process focused,[104] targets are achievable within a specified timeframe,[76] and measures are actionable.[32]

Two approaches referenced *gaming the system* and explicitly highlighted the avoidance of perverse effects[33] or perverse incentives[27] by requiring that the measure has been tested for unintended consequences.

Several approaches indicated additional *measurement quality characteristics* that measures had to display in order to be eligible. This included precision and discriminating power,[70] being free of measurement bias,[119] robust to minor changes,[62] representing the majority of care but being sensitive to change[28, 35] to ensure that change can be measured.[102] Other approaches specified that the measure has adequate controls for covariates,[85] it can be risk-adjusted or stratified,[114] all measurement components are clearly defined,[52, 77] and the measure is capable of detecting misuse, overuse, and underuse of care to be suitable to promote accountability.[100]

Multiple approaches also mentioned the need for *parsimony*. Criteria descriptions included not duplicating existing measures,[117] not allowing overlap with other measures[93] ensuring that indicators are not redundant,[23, 30] not exceeding an appropriate number of indicators,[63, 117] and adhering to the general principle that fewer measures are better than more.[112] One described approach to parsimony included removing indicators that are identical or very similar in nature and if possible, indicators sourced from either national bodies or global health organizations should be prioritized.[23]

Some of the approaches incorporated the *source* of the measure into the prioritization criterion. This was described as being developed with physician input[71] or, more broadly, other interest holder groups being involved in a transparent development process[117] in another publication. Other agencies required a consensus-based process[43] or stated the need for reliable sources.[22, 38]

Several approaches highlighted the need to demonstrate *usefulness* for internal purposes by adding value,[74] or external purposes, such as the accreditation process;[114] to promote shared accountability across providers or continuous learning;[100] or for public reporting and payment reform.[41]

3. **Findings**

Main Findings for Guiding Question 2: How could the current NHQDR measure selection prioritization criteria be updated?

The review of alternative approaches in the literature, discussions with key informants, and discussions with the NHQDR team revealed a number of issues. Some of these could be translated into proposed revised criteria for the NHQDR, others could form the basis of further discussions. The following documents issues relevant to a potential update of the NHQDR criteria, organized by the NHQDR criteria domains recommended in 2010 (Criterion A to F, see Table 3).

- Criteria and Issues *2010 Recommendations for the NHQDR*[142]
  - Criterion A: *Improvability*: Multiple discussions with key informants centered around improvability, both in the context of drivers of health as well as using process measures rather than health outcomes. The discussions around drivers of health focused on who should be held accountable for aspects that are not under the control of the healthcare system. Process measures are easier to influence and measure than health outcomes, while health outcomes can be distal measures and are influenced by many aspects outside of the healthcare system. Health outcomes are nonetheless the most interesting aspect for policy makers, i.e., the primary audience of the NHQDR. The NHQDR serves a surveillance function for the U.S., and the consensus among key informants was that the NHQDR provides an objective measure of healthcare quality and disparities and should be independent from whether and in what time frame measures can improve.
  - Criterion B: *Sound measure available*: In the context of a developing field where our understanding of drivers of health evolves, it is difficult to limit to areas for which measures are readily available. Key informants suggested that the NHQDR may need to proactively foster the development of new measures to advance the field. Discussions also highlighted that the availability or lack of availability of measures should be considered independently from the priority of the measure (i.e., in some cases, efforts may need to be made to encourage the development of measures).
  - Criterion C: *Applicability to national priorities*: This criterion acknowledges that priorities may change over time and need to be able to address events such as the recent COVID-19 pandemic. However, a shift to a more general "alignment" terminology may be most appropriate.
  - Criterion D to F (at least one needs to be met): Criterion D: *Value*: A recurring issue in the literature and discussions with key informants was that value means different things to different interest holders. For example, readers may not guess that the conceptualization of value in the 2010 IOM recommendations included narrowing a defined quality gap. Criterion E: *Population equity*: While key informants and the literature stressed the importance of equity, measures of disparities are generally more common than measures of equity. Criterion F: *Geographic and health systems equity*: the NHQDR has traditionally served as a documentation of the existing variation in the U.S. healthcare system, but more work is needed to identify key domains, and

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discussions should focus more explicitly on drivers of health according to key informants.

We also reviewed the primary and secondary criteria and the balancing principles that were assumed to be applied to the NHQDR up to 2010 (the time of the new recommendations for the NHQDR included in the 2010 IOM Report).

- Criteria and Issues *Presumed NHQDR Primary Criteria Used to 2010*[142]
  - o *Importance*: Discussions with key informants emphasized that importance is a necessary but not sufficient criterion to be met for a measure in order to be included in the report. Many measures are important, but not all can be included in the NHQDR. We also note that importance has multiple aspects as originally conceptualized for the NHQDR (impact on health, meaningfulness, susceptibility to being influenced by the healthcare system), which may not be obvious to users of the NHQDR or even those who are prioritizing measures. Importance is not an explicit criterion in the 2010 recommendations outlined above, but the starting point for identifying measures is an environmental scan for importance.[142] It was also defined very broadly and included susceptibility to being influenced by the health system (e.g., high utility for directing public policy, and sensitive to change).[142]
  - o *Scientific soundness*: The criterion was the subject of many discussions and there are conflicting views regarding the need to include this criterion. It was part of the criteria to prioritize measures for the NHQDR for many years. The criterion was not included in the 2010 recommendations for the NHQDR. Rather, it was assumed that AHRQ uses only consensus-based endorsed measures. As outlined, the NHQDR uses other measure compendiums to populate the annual report, and establishing the scientific soundness should have happened in that original compendium. It does not seem critical for NHQDR staff to second-guess the scientific merit of the measures. However, whether a measure is sound may depend on the individual approach to reviewing, revising, or developing measures and the evidence table in Appendix C shows that potential sources for the NHQDR vary to what extent measures undergo scientific scrutiny. Key informants noted that scientific soundness should not be equated with being based on randomized controlled trial (RCT) evidence. In the face of shifting priorities, such as the acknowledgment of the importance of equity, there may not be sufficient relevant RCT-evidence for equity data or other important questions. Key informants also emphasized the need for an additional mechanism, such as interest group consensus, or accepting criteria applied in organizations that work closely with community organizations; in some cases, the importance of measures must outweigh scientific soundness.
  - o *Feasibility*: The literature and key informants varied in their opinions regarding whether feasibility should be a primary, secondary, or no criterion to select measures. The criterion was not included in the 2010 recommendations for the NHQDR. Discussion with key informants for this update emphasized measures should be selected based on content validity. Not everything that can be measured matters, and not everything that matters can be measured. Some key informants stressed the role of the NHQDR as a tool to drive change.
  - o *Usability*: Perceived usefulness and face validity of measures depend on the audience. The primary audience of the NHQDR is Congress, and one of the first considerations should be whether measures make sense to Congress and allows members of

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Congress or Congressional staffers to get a valid picture of the U.S. healthcare quality and care disparities. However, in practice, the NHQDR is much more widely used, for example the website is a publicly available tool to identify up-to-date evidence of disparities. Key informants stressed that measures need to be accepted by the community for which the NHQDR provides data. The views and needs of the audience, and their confidence in the measures to provide an accurate picture of the nation's healthcare system, is critical. Responsiveness to the field will help to optimize the use of the NHQDR.

o *Type of measure*: There is currently no consensus that process measures are superior to other measures, in particular outcome measures. The preference for process over outcomes had already been revisited in 2010.[19] The recommendations acknowledged that outcome measures can be too distal or rare to provide an appropriate overview of healthcare quality. However, the committee encouraged the development or adoption of outcome measures because these are of interest to policy makers, particularly outcomes associated with the implementation of specific programs and policy changes. The recommendations did not include prioritization criteria that address the nature of the measure (i.e., structure, process, or outcome).[142] While processes are easier to measure and are more directly under the control of healthcare systems, , key informants stressed that we need to be confident that the process is strongly linked to health outcomes. If the process is not clearly related or has not been demonstrated to impact health outcomes, its relevance for assessment is not obvious and it is likely not worth assessing. The implementation of value-based care in healthcare systems has further accelerated the emphasis on patient-centered outcomes in the last decade. Public health and population-based measures are also very different from patient-focused outcomes addressing individual patients and the distinctions regarding the type of measures may not always apply.

- Criteria and Issues *Presumed NHQDR Secondary Criteria Used to 2010*[142]
  o *Applicability to general population*: Key informants stressed that applicability to the general population may not always be a good criterion, particularly when aiming to document disparities. Given the large variation in settings and sites addressed in the NHQDR, some measures may be important but unique to a specific population. Issues that are important to underprivileged or remote communities may be difficult to relate to in more affluent neighborhoods, especially when shifting focus from the treatment of illness to promoting well-being. One example is access to air conditioning – a key element for well-being in underprivileged communities, but perhaps difficult to relate to for other groups as a quality measure. As the 2010 IOM report states,[19] "At times, equity considerations may need to trump the overall valuation (for instance, if there is a large disparity gap, but the overall difference between national performance and the aspirational performance level is relatively small). Additionally, there may be measurement areas where the impact of a condition for one of the priority populations is profound. In these cases, the needs of the population could have precedence even if the overall valuation did not rank the measure highly for the entire population of the nation."
  o *Availability of data*: The criterion indicates that data should be available regularly and recently. While the NHQDR can introduce new or omit prior measures at all times, key informants stressed the need for consistency across reports. The ability of

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measures to track the effect of policy levers requires stability over time in documentation and any changes in measure characteristics are detrimental for the use of trend analyses. Data availability was not an explicit criterion in the 2010 IOM committee recommendations, but the decision-making process for selecting measures included data availability as the last step (if an appropriate data source exists, the measure will be included in the NHQDR; if not, the process should support the acquisition of relevant data).

- o *Ability to link* to established indicator sets: Traditionally, the ability to link to established indictor sets such as the Healthy People series, was a criterion for NHQDR measures.[147] The approaches identified in the literature show the large variation in the prioritization criteria and process for measures. While harmonization of measures is important to allow comparisons, the NHQDR may decide to focus on unique aspects. Key informants highlighted the need for transparency and a documented rationale for selecting measures, but raised also that the NHQDR may need to prioritize unique aspects of quality of care and care disparities to fulfil its aims. Key informants and published literature emphasized the importance of compatibility of data that enables comparisons. Both, to be able to detect geographic variation within the U.S., as well as to compare the U.S. healthcare system with other countries. One necessary update to the 2010 NHQDR criterion is to establish the link to the published Healthy People 2020 and the goals for Healthy People 2030, as the original criterion referred to Healthy People 2010.[142]
- o *Multivariate data*: The criterion refers to the data source supporting multivariate modeling (e.g., by providing information on socioeconomic status, race and ethnicity). This criterion is not found in other approaches and key informants struggled with understanding its meaning.

- Criteria and Issues *Presumed NHQDR Balancing Principles Used to 2010*[142]
    - o *Balance across health conditions*: The principle of balance was unanimously considered sound and important and is also found in other systems.[39] Of practical importance is also which health conditions are being selected for the NHQDR, given that the number of condition-independent quality and disparity measures are limited. Key informants stressed the need for a deliberate curation of health conditions and care settings.
    - o *Balance across sites of care*: The principle of balance across sites also has high face validity and was supported by key informants. However, critical for this principle is that adding another setting or care site to the NHQDR can add many additional measures, which makes the need for curation across all measures captured in the NHQDR even more critical.
    - o *Balance: At least some state data*: The main issue regarding this criterion that was emphasized in discussions with key informants was that the NHQDR is a federally mandated report. Key informants highlighted that there are measures where only some states provide data. Thus, the interpretation and implication of the criterion is unclear (e.g., do some measures only apply to some states but not others? If a measure is important, should there be data for all states)? The 2010 IOM report indicated that the NHQDR includes state data for 26 of 46 core measures on the State Snapshot website (e.g., access measures, measures from Centers for Disease Control and Prevention data).[148]

     o *Balance: Multivariate models*: The criterion stated 'at least some multivariate models' and is different from the secondary criterion multivariate data described earlier. It was difficult to understand even for experts in the field. It likely refers to the ability to document disparities. Since our thinking and our knowledge regarding health equity, pertinent subgroups, and drivers of health is evolving, it may not be appropriate to make the availability of an existing model that includes the measure a condition for selecting the measure for the NHQDR.

Issues with the balancing principles evolved mainly around the need for curation to determine the most salient measures for the NHQDR. Key informants and the literature highlighted the importance of a body that provides an overall perspective ("big picture" function), which can be easily lost in the process of developing measures. While each workgroup charged with developing measures will provide excellent input in their area of expertise, this does not guarantee that the NHQDR in its entirety has a good mechanism to provide an overview of the quality of care and to reflect existing disparities. Key informants reflected that establishing a process for removing and criteria for retiring measures is as important as adding measures. Rather than continually adding measures, a process should be developed for critically reviewing newly proposed as well as included measures, and formulating a process for retiring measures. Discussions highlighted that the curation of measures is most important for the annual report. For the online tool, this issue may need to be framed around the best display of data rather than the selection of measures. Furthermore, while the principle of parsimony is salient, it is in the case of the NHQDR not linked to assessment burden as in many published approaches, given that the NHQDR uses already existing measures for the annual report.

3.2.1 Proposed Revision of the Criteria to Prioritize Measures

The following suggestions were derived from considerations regarding the unique nature and purpose of the NHQDR, the review of alternative criteria sets and approaches, discussions with key informants, a critical review of the current NHQDR criteria, and discussions with the NHQDR team as outlined in more detail in the method section.

The proposed revision of criteria to prioritize NHQDR measures is documented in Figure 3 which shows the reduced and revised list of criteria proposed for the NHQDR.

Figure 3. Proposed Revised NHQDR Criteria to Prioritize Measures

- **Alignment** (importance to NHQDR aims and objectives, framework, and national priorities)
- **Usability and acceptability** (methodological simplicity and interest holder acceptance)
- **Compatibility** (ability to provide comparative data for national and international comparisons)
- **Impact disparities and drivers of health** (ability to document disparities across population and communities and sensitivity to drivers of health)
- **Balance** (curation of salient measures with balance across health conditions and sites of care)

The next section, Findings for Guiding Questions 2a, introduces each criterion. Table 5 provides a summary of which prior criteria for the NHQDR were removed or revised.

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Table 5. Summary of Changes Compared to Existing NHQDR Criteria

Existing Criterion	Suggestion for Change
Criterion A: Improvability	Remove
Criterion B: Sound measure available	Remove
Criterion C: Applicability to national priorities	Revise: Alignment
Criterion D: Value	Remove
Criterion E: Population equity	Revise: Impact disparities and drivers of health
Criterion F: Geographic and health systems equity	Revise: Impact disparities and drivers of health
1. Importance	Revise: Alignment
2. Scientific soundness	Remove
3. Feasibility	Remove
4. Usability	Revise: Usability and acceptability
5. Type of measure	Remove
Applicability to general population	Remove
Availability of data	Remove
Ability to link	Revise: Compatibility
Multivariate data	Remove
Balance across health conditions	Revise: Balance
Balance across sites of care	Revise: Balance
Balance: at least some state data	Remove
Balance: at least some multivariate models	Remove

We consolidated multiple criteria. It should be noted that removal of individual criteria does not indicate that the aspect is not important; we removed criteria that are not applicable to all measures included in the NHQDR, those that are already addressed in other criteria, or those that conceptually should not limit the NHQDR (e.g., feasibility, availability of recent data, state data or multivariate models were removed).

3.2.2 Findings for Guiding Question 2a: What is the operationalized definition of each updated prioritization criteria?

The suggested update of the criteria to prioritize measures includes five criteria outlined below.

Alignment refers to alignment with the NHQDR goals and objectives based on the congressional mandate for the annual reports and focused on the suitability and importance of measures to provide an accurate snapshot of the U.S. healthcare system in a given year. There needs to be alignment with the unique role of the NHQDR in providing information on the U.S. healthcare system, in particular the focus on providing a description of the healthcare quality and care disparities, rather than focus on assessing the performance and/or holding specific organizations accountable. There should be alignment with the NHQDR-specific framework depicting the domains of care quality and care disparities. Furthermore, the NHQDR needs to be aligned with national priorities such as the National Quality Strategy[149] and commitment to maternal health.[150] This criterion acknowledges that priorities can change over time. The report should consider both the primary audience (congress receiving yearly reports) and the audience in practice (i.e., likely wide range of audience using the web tools).

Usability and acceptability refers to prioritizing the user of the NHQDR by prioritizing measures that are easy to understand and interpret, and that are accepted by the interest holders and community that the report is evaluating. The trust in measures needs to be established; this is of particular importance for measuring disparities and equity. Measures need to reflect patient experiences within and across all communities and to establish that the right aspects are being

measured. This criterion also emphasizes aspects that were previously discussed in the context of the importance of a measure, i.e., measuring aspects of healthcare that have impact on health, that are meaningful, and that are susceptible to being influenced by the health system. In addition, the concept of scientific soundness (e.g., reliability and validity of the measure, compatibility of measures with evolving clinical standards) should also be considered as part of usability and acceptability. Establishing usability and acceptability can be achieved through selecting appropriate sources for measures, interest holder input, and potentially eliciting feedback on measures. The NHQDR uses measures collected in other measure compendiums and reassessing the scientific soundness of the measure is likely a time-consuming and duplicative process that should be avoided; however, the NHQDR nonetheless needs to determine whether a measure is right for the purpose and prioritize the most salient measures among all available measures.

Compatibility refers to the ability of NHQDR measures to be compared to results of other national measure compendiums (e.g., Healthy People 2030) or international sources (e.g., OECD comparisons) given the unique healthcare landscape of the U.S. compared to other industrialized high-income countries. Nonetheless, the NHQDR may need to provide a unique collection of measures to appropriately document the U.S. healthcare delivery in a given year.

Impact disparities and drivers of health is defined as the ability to highlight disparities and being sensitive to drivers of health. This may entail re-reviewing how disparities are currently displayed and tracked. More deliberate focus should be on assessing equity. While the NHQDR traditionally focuses on healthcare disparities and equity, rather than public health disparities and equity, drivers of health go beyond healthcare performance and the NHQDR would benefit from using measures that are sensitive to drivers of health. Measures may include structural, process, or outcome measures, in particular those within healthcare that aim to address drivers of health (e.g., facilities may offer help with transportation, adjust schedules to allow working parents to keep appointments, etc.). Furthermore, the measurement process should be informed by current knowledge (e.g., shifting focus from race categories to postcodes). This criterion relies on existing datasets to include patient, facility, and community-level information to allow subgroup analyses to detect disparities between groups.

Balance entails ensuring that the NHQDR reports equally or proportionally across health conditions as well as sites of care where no condition- or site-independent measures can be identified. Balance must be established through deliberate curation of measures included in the NHQDR. Balance requires that measures meet a higher threshold than importance of the measure (many measures are important) and supports parsimony of the measure set. The sheer number of measures may be detrimental to the goals that the NHQDR wants to achieve in providing an annual snapshot of the U.S. healthcare system. While individual workgroups developing measures for their area of expertise will prioritize measures and avoid redundancy within their field, the workgroup will not know about the conceptual overlap with other measures in other content areas. It is critical that measures included in the NHQDR are not only reviewed within content areas but also across all included measures, services, and care sites to avoid duplication and conceptual overlap that adds little information to the report. Ensuring balance entails reviewing newly proposed measures as well as establishing a process to retire measures.

3.2.3 Findings for Guiding Question 2b: What type of health care quality measures would help the NHQDR's primary audience monitor the effectiveness of health policy levers?

Only some of the identified approaches addressed how the quality measures would influence policy, let alone help monitor the effectiveness of health policy levers. The exception were approaches embedded in an initiative to help drive national and local action for improving health with clear links to policy levers such as the national quality strategy.[19]

Some of the approaches indicated that the measures were designed to assess quality and define policy accordingly,[62] evaluate the system in terms of the policy aims,[63, 69, 110, 134] help inform public and private policy action,[21, 100, 118] or were chosen to reflect policy and management functions of the government and defined public goals of the health system.[126]

Some initiatives saw the measures as a tool to draw attention to existing issues,[112] utilized measures to help make quality in the healthcare system more transparent,[34, 58] or selected measures that were explicitly actionable.[40, 96] Some publications suggested that the measures offer opportunity to monitor system performance,[28, 55] help benchmark,[80, 137] compare across countries,[127] compare across sectors,[27] may help to impose penalties and prizes according to performance,[81, 95] or offer opportunity for accountability.[121] Others indicated that measurement is intended to help plan and set priorities,[113] support agenda setting,[135] or help policymakers to prioritize efforts when resources are limited;[134] while one approach outlined the need to recognize different levels and lines of accountability.[46]

We also discussed with key informants what type of healthcare quality measures should be included in the NHQDR to facilitate policy evaluations. Some experts indicated that tracking the effect of policy should be the subject of research publications, rather than being an integral part of the NHQDR. Key informants indicated that the measures need to be consistent over time to allow monitoring over time and to be able to detect an effect of policy changes.

3.3 Main Findings for Guiding Question 3: How could the new NHQDR measure selection prioritization criteria be applied?

The evidence table in Appendix C shows how criteria are derived and applied in other approaches. The process included predominantly literature reviews and formal consensus development procedures.

We developed a smaller set of consolidated criteria for the NHQDR (Figure 3). We suggest that these be used to evaluate measures for individual topics within workgroups, with the workgroup using the criteria as guiding principles. It became clear in key informant calls and to some extent in the identified literature, that there must be a group that continuously monitors the measure selection, ensures balance across measures, and provides oversight of the curation of measures to assess compatibility of any new proposed measures, and to screen for existing measures that should be retired. While several identified approaches stressed the need for parsimony, we found few suggestions on how to achieve this. One key informant indicated that streamlining measures will require more emphasis on finding consensus within and across groups rather than accepting measures too readily based on individual interest holders. The idea of a body that has a big picture view, that looks across clinical areas and settings, and that checks for alignment to the report's aims and audiences as well as overlap or redundancy across individual domains (e.g., access), dimensions (e.g., chronic health monitoring, diabetes), and

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measures (e.g., yearly exams). Given the importance of this function, input from interest holders may need to be elicited and incorporated in the process.

The proposed updated set of criteria for the NHQDR still leaves room for interpretation and translation and outlines general principles that should be applied to measures to determine which should be prioritized for the NHQDR. Identified information across sources suggested that it is difficult to be prescriptive and at the same time ensure that the criteria remain relevant over time in the face of different challenges, changes in terminology, as well as changes in priorities. The most pragmatic approach may be to state in each annual report how the criteria were operationalized to provide transparency over the measure prioritization mechanism.

4. Summary and Implications

This technical brief provides an overview of existing criteria to prioritize care quality and care disparity measures. A substantial number of published approaches exists that can inform the NHQDR process. The identified approaches differed considerably in the number of criteria applied to prioritize measures, as well as the style or format of the individual criteria. Commonly used criteria to select measures across international approaches included the importance, validity, feasibility, and reliability of measures. All identified approaches also included additional criteria to select measures, such as *parsimony* and *acceptability* of the measures. As a result of discussions and supporting literature, we made concrete suggestions for updating the criteria to prioritize measures for the NHQDR. We proposed five criteria: *Alignment; Usability and acceptability; Compatibility; Impact disparities and drivers of health*; and *Balance*.

We have considerably shortened the list of prioritization criteria by removing some criteria based on key informant input, the available literature and discussions with the NHQDR team. We consolidated many criteria that have been suggested for the NHQDR over the last two decades. Given the unique characteristics of the NHQDR—e.g., measures for the NHQDR are selected from existing measure compendiums, and the unique aims of the NHQDR to provide a meaningful snapshot of the healthcare system—the list does not include criteria that are prominent in other, primary measure collections, such as importance, validity, reliability, and feasibility. Similarly, instead of re-establishing the scientific soundness of existing measures, we suggest that the NHQDR focuses on identifying measures that align with the aims and objectives of the NHQDR, i.e., to provide an overview of the quality of care in the U.S. in a given year. This entails determining whether the measure is usable and acceptable for its purpose, is compatible with at least some nationally or internationally measurement efforts, and considers disparities and drivers of health. A possible downside of removing scientific soundness as an explicit criterion may d be that scientific soundness is too readily assumed, where sources used different criteria to select measures or other aspects such as interest holder opinions are favored over objective measurement characteristics.

Finally, while the purpose of the review of the NHQDR measure criteria was not to decrease the number of measures, given that the NHQDR currently includes over 500 measures, a consolidated list of criteria will help with any future efforts to reassess the included measures. The criteria can be used to prioritize measures for the annual report to Congress. The data tool of the NHQDR is presented in a very user-friendly format and it may not need any reduction of measures, in particular since the NHQDR is documenting a complex healthcare system, but may benefit from providing a summary that is curated based on the suggested criteria.

4.1 Strengths and Limitations

We conducted a comprehensive literature review search, engaged key experts, and followed up with numerous organizations who have published measurement criteria. While we reviewed thousands of sources, it should be noted that this project was based on a scoping review, rather than a full systematic review of the literature. We screened numerous scientific publications and grey literature sources but relied to some extent on input from key informants to suggest sources for this complex area. We used an inclusive definition of criteria; nonetheless, there are likely other important approaches to measuring healthcare quality and disparities that have been missed because the authors did not publish their approach.

While we spoke to key content experts in the field, the number of key informants that could be engaged in this project was limited and there is no doubt that there are a number of additional important interest holders that could provide further important perspectives. This may include interest holders outside of the academic and policy realm, such as "disrupters" who may have novel and innovative ideas of how to revise the NHQDR measure criteria because of their different approach to healthcare quality and disparities. This also includes patient representatives as well as users of the NHQDR such as Congress and the likely diverse group of users of the online NHQDR data tool. A particular question for Congress would be whether linking the NHQDR more closely to policy evaluations would be useful. Future initiatives to elicit these perspectives would be valuable.

The proposed updated set of criteria to prioritize measures aims to capture the unique nature of the NHQDR and to reflect current discussions and priorities. The criteria leave room for interpretation and should be defined for each annual report to transparently document their operationalization. The literature shows the large number of criteria that have been proposed to prioritize quality of care and care disparities measures. While all likely contribute to achieving a reliable and valid picture of the healthcare system, it also needs to be acknowledged that some criteria and guiding principles cannot be simultaneously optimized. For example, sources emphasized the importance of continuity of measures as well as the importance of retiring measures.

Finally, the task of this technical brief was to suggest an update of the current approach and to add dimensions that had been identified as important but missing in the current approach. Future efforts may want to re-review the proposed criteria and decide whether a further re-conceptualization is warranted, in particular after eliciting end user feedback for the NHQDR.

4.2 Next Steps

The proposed revised criteria should be applied to selected content areas to evaluate their impact. The proposed criteria set will be tested internally by applying these to patient safety, access to care, diabetes care, cardiovascular care, and cancer care measures to assess the feasibility and usefulness of the criteria in practice.

While some of the updates could be easily incorporated into the NHQDR process, other issues were also brought up in the process that may require further deliberations. For these it may be necessary to initiate additional discussions within AHRQ and the interagency workgroup supporting the NHQDR, ideally with input from interest holders, to determine to what extent the NHQDR should make further changes to the criteria or the process of applying the criteria to prioritize measures.

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Abbreviations and Acronyms

AHRQ	Agency for Healthcare Research and Quality
CINAHL	Cumulative Index to Nursing and Allied Health Literature
EPC	Evidence-based Practice Center
IOM	Institute of Medicine
NASEM	National Academies of Sciences, Engineering, and Medicine
NQF	National Quality Forum
SEADs	Submit Supplemental Evidence and Data for Systematic Reviews

Appendix A. Search Strategy

Database Search
Date: 12/31/2024

PubMed
Results – 280
("Healthcare Quality Indicator"[Title/Abstract] OR "Healthcare Quality Indicators"[Title/Abstract] OR "care indicator"[Title/Abstract] OR "care indicators"[Title/Abstract] OR "care quality"[Title/Abstract] OR "Health metric"[Title/Abstract] OR "Health metrics"[Title/Abstract] OR "care metric"[Title/Abstract] OR "care metrics"[Title/Abstract] OR "quality of care"[Title/Abstract] OR "equity in healthcare"[Title/Abstract] OR "healthcare disparity"[Title/Abstract] OR "healthcare disparities"[Title/Abstract] OR "quality indicators, health care"[MeSH Terms] OR (("benchmarking/organization and administration"[MeSH Terms] OR "benchmarked"[Title/Abstract] OR "benchmarking"[Title/Abstract] OR "benchmark"[Title/Abstract] OR "benchmarks"[Title/Abstract]) AND ("health care"[Title/Abstract] OR "healthcare"[Title/Abstract])
 AND
 "measurement criteria"[Title] OR "National Healthcare Quality and Disparities Reports" OR NHQDR[Title] OR disparities assessment[Title] OR disparities measurement[Title] OR care equity[Title] OR equity measurement[Title] OR equity assessment[Title] OR consensus [Title] OR Delphi[Title] OR RAND/UCLA[Title] OR ((selecti* [Title] OR priorit* [Title] OR rank*[Title] OR appropriateness [Title]) AND (method[Title] OR process[Title] OR procedure[Title] OR approach[Title] OR committee*[Title] OR panel[Title] OR expert*[Title]))
Article Type:
Consensus Development Conference, Consensus Development Conference, NIH, Government Publication, Guideline, Meta-Analysis, Observational Study, Practice Guideline, Review, Systematic Review, Technical Report, Validation Study

APA PsycINFO
Results – 211
(((((IndexTermsFilt: ("Quality of Care")))) OR (((Any Field: ("Healthcare Quality Indicator")) OR (Any Field: ("Healthcare Quality Indicators")) OR (Any Field: ("care indicator")) OR (Any Field: ("care indicators")) OR (Any Field: ("care quality")) OR (Any Field: ("Health metric")) OR (Any Field: ("Health metrics")) OR (Any Field: ("care metric")) OR (Any Field: ("care metrics")) OR (Any Field: ("quality of care")) OR (Any Field: ("equity in healthcare")) OR (Any Field: ("healthcare disparity")) OR (Any Field: ("healthcare disparities")) OR (Any Field: ("quality indicators, health care")))) OR (((((title: (benchmarked))) OR ((title: (benchmarking))) OR ((title: (benchmark))) OR ((title: (benchmarks)))) OR (((abstract: (benchmarked))) OR ((abstract: (benchmarking))) OR ((abstract: (benchmark))) OR ((abstract: (benchmarks))))) AND (((((title: ("health care"))) OR ((title: (healthcare)))) OR (((abstract: ("health care"))) OR ((abstract: (healthcare))))))))) AND (((((title: ("measurement criteria")) OR (title: ("National Healthcare Quality and Disparities Reports")) OR (title: (NHQDR)) OR (title: (disparities assessment)) OR (title: (disparities measurement)) OR (title: (care equity)) OR (title: (equity measurement)) OR (title: (equity assessment)) OR (title: (consensus)) OR (title: (Delphi)) OR

(title: (RAND/UCLA)))) OR (((title: (selecti*)) OR (title: (priorit*)) OR (title: (rank*)) OR (title: (appropriateness))) AND ((title: (method)) OR (title: (process)) OR (title: (procedure)) OR (title: (approach)) OR (title: (committee*OR panel)) OR (title: (expert*))))) AND Publication Type: Peer Reviewed Journal

CINAHL Complete (EBSCOhost)
Results – 7
ZU benchmarking
OR ti("Healthcare Quality Indicator" OR "Healthcare Quality Indicators" OR "care indicator" OR "care indicators" OR "care quality" OR "Health metric" OR "Health metrics" OR "care metric" OR "care metrics" OR "quality of care" OR "equity in healthcare" OR "healthcare disparity" OR "healthcare disparities" OR "quality indicators, health care") OR ab("Healthcare Quality Indicator" OR "Healthcare Quality Indicators" OR "care indicator" OR "care indicators" OR "care quality" OR "Health metric" OR "Health metrics" OR "care metric" OR "care metrics" OR "quality of care" OR "equity in healthcare" OR "healthcare disparity" OR "healthcare disparities" OR "quality indicators, health care")
OR ti("benchmarked" OR "benchmarking" OR "benchmark" OR "benchmarks") OR ab("benchmarked" OR "benchmarking" OR "benchmark" OR "benchmarks") AND ti("health care" OR "healthcare") OR ab("health care" OR "healthcare")
AND
ti("measurement criteria" OR "National Healthcare Quality and Disparities Reports" OR NHQDR OR disparities assessment OR disparities measurement OR care equity OR equity measurement OR equity assessment OR consensus OR Delphi OR RAND/UCLA)
AND
ti((selecti* OR priorit* OR rank* OR appropriateness) AND ti(method OR process OR procedure OR approach OR committee* OR panel OR expert*))

Social Work Abstracts
Results – 2
ZU benchmarking
OR ti("Healthcare Quality Indicator" OR "Healthcare Quality Indicators" OR "care indicator" OR "care indicators" OR "care quality" OR "Health metric" OR "Health metrics" OR "care metric" OR "care metrics" OR "quality of care" OR "equity in healthcare" OR "healthcare disparity" OR "healthcare disparities" OR "quality indicators, health care") OR ab("Healthcare Quality Indicator" OR "Healthcare Quality Indicators" OR "care indicator" OR "care indicators" OR "care quality" OR "Health metric" OR "Health metrics" OR "care metric" OR "care metrics" OR "quality of care" OR "equity in healthcare" OR "healthcare disparity" OR "healthcare disparities" OR "quality indicators, health care")
OR ti("benchmarked" OR "benchmarking" OR "benchmark" OR "benchmarks") OR ab("benchmarked" OR "benchmarking" OR "benchmark" OR "benchmarks") AND ti("health care" OR "healthcare") OR ab("health care" OR "healthcare")

AND
ti("measurement criteria" OR "National Healthcare Quality and Disparities Reports" OR NHQDR OR disparities assessment OR disparities measurement OR care equity OR equity measurement OR equity assessment OR consensus OR Delphi OR RAND/UCLA)

AND

ti((selecti* OR priorit* OR rank* OR appropriateness) AND ti(method OR process OR procedure OR approach OR committee* OR panel OR expert*))

Cochrane Database of Systematic Reviews

Results - 0

("Healthcare Quality Indicator" OR "Healthcare Quality Indicators" OR "care indicator" OR "care indicators" OR "care quality" OR "Health metric" OR "Health metrics" OR "care metric" OR "care metrics" OR "quality of care" OR "equity in healthcare" OR "healthcare disparity" OR "healthcare disparities")ti OR MeSH descriptor:"quality indicators, health care"

OR

MESH descriptor:"benchmarking MeSH Terms OR ("benchmarked" OR "benchmarking" OR "benchmark" OR "benchmarks"):ti AND ("health care" OR "healthcare"):ti

AND

("framework" OR "frameworks" OR "conceptual model" OR "conceptual models" OR "conceptualization" OR "logic model"):ti

Campbell Collaboration

Results - 0

(Title)"healthcare quality"

(Title)"health care quality"

(Title)"quality of care"

(Title)"care indicator"

(Title)"care indicators"

(Title)"health metrics"

intitle:equity OR intitle:healthcare

intitle:disparities OR intitle:healthcare

intitle:healthcare OR intitle:framework

intitle:healthcare OR intitle:frameworks

intitle:"health care" OR intitle:framework

intitle:"health care" OR intitle:frameworks

FR: Search Info: "Supported operators…the Keyword search field, you can combine terms. For example: intitle:female OR intitle:women will show results containing pages with "female" and "women" in the title."

Grey Literature Sources

Date: 11/27/2023

AcademyHealth
https://academyhealth.org
Assistant Secretary for Planning and Evaluation

https://www.aspe.hhs.gov

Bay Area Regional Health Inequities Initiative
https://barhii.org

Centers for Medicare and Medicaid Services
https://www.cms.gov

Department of Health and Human Services
https://www.hhs.gov

eLife
https://elifesciences.org

Food and Drug Administration
https://www.fda.gov

Health Center Program Uniform Data System (UDS)
https://data.hrsa.gov/tools/data-reporting/program-data

Health Evolution
https://www.healthevolution.com

Health Policy Institute of Ohio
https://www.healthpolicyohio.org

Health Quality Council of Alberta
https://hqca.ca

Health Resources in Action
https://hria.org

Health Resources and Services Administration (HRSA)
https://www.hrsa.gov

Indian Health Service
https://www.ihs.gov/

Institute for Healthcare Improvement
https://www.ihi.org

International Learning Collaborative
https://ilccare.org

John Hartford Foundation
https://www.johnahartford.org

Mary Black Foundation
https://maryblackfoundation.org

Massachusetts Health Policy Commission
https://www.mass.gov

National Academy for State Health Policy
https://nashp.org/national-standards-for-cyshcn-measures-compendium/

National Academy of Medicine
https://nam.edu

National Association of County and City Health Officials
https://www.naccho.org/

National Association for Healthcare Quality
https://nahq.org

National Committee for Quality Assurance
https://www.ncqa.org

National Governors Association

https://www.nga.org/bestpractices/behavioral-health/
National Institute on Aging
https://www.nia.nih.gov
National Institute on Drug Abuse
https://nida.nih.gov/
National Quality Forum
https://www.qualityforum.org/Home.aspx
National Institute on Minority Health and Health Disparities
https://www.nimhd.nih.gov
Niagara Health
https://www.niagarahealth.on.ca/site/home
Patient-Centered Outcomes Research Institute
https://www.pcori.org
Robert Wood Johnson Foundation
https://www.rwjf.org
Rural Health Information Hub
https://www.ruralhealthinfo.org
University of Delaware
http://dehealthequityguide.weebly.com
U.S. Preventive Services Task Force (USPSTF)
https://www.uspreventiveservicestaskforce.org/uspstf/
Veterans Health Administration
https://www.va.gov
World Health Organization
https://www.who.int

Appendix B. List of Included, Background, and Excluded Publications

This appendix shows the list of included, background studies, and excluded studies with reasons for exclusion. Background papers provided more information on the topic or were retained for reference-mining. We recorded only one reason for exclusion per publications.

Included Publications

1. Culture of Health Action Framework. Vision to Action: A Framework and Measures to Mobilize a Culture of Health: n.d. https://www.nursing.umaryland.edu/media/son/academics/professional-education/mdac-poster-2017/presentations/Hassmiller---RWJ000-CoH-Action-Framework-Page-Hi-Res_nocrop.pdf. *Multiple publication*

2. Agency for Healthcare Research and Quality. AHRQ Quality Indicators—Guide to Inpatient Quality Indicators: Quality of Care in Hospitals—Volume, Mortality, and Utilization Agency for Healthcare Research and Quality. Rockville, MD: 2002. https://www.ahrq.gov/downloads/pub/inpatqi/iqi_guide.pdf. *IncludeDE_Framework and Measures*

3. Agency for Healthcare Research and Quality. Guidelines and Measures Updates. Rockville, MD; July 2018. https://www.ahrq.gov/gam/updates/index.html. Accessed on March 11, 2024. *IncludeDE_Framework and Measures*

4. Al-Ghamdi M, AlTamimi M, Al-Azmi N, et al. Development of national framework for health status and health system performance indicators in Saudi Arabia. J Infect Public Health. 2023 Feb;16(2):295-302. doi: 10.1016/j.jiph.2022.12.020. PMID: 36630837. *IncludeDE_Framework and Measures*

5. Alvidrez J, Castille D, Laude-Sharp M, et al. The National Institute on Minority Health and Health Disparities Research Framework. American Journal of Public Health. 2019 2019/01/01;109(S1):S16-S20. doi: 10.2105/AJPH.2018.304883. *Multiple publication_framework*

6. Arah OA, Klazinga NS, Delnoij DM, et al. Conceptual frameworks for health systems performance: a quest for effectiveness, quality, and improvement. Int J Qual Health Care. 2003 Oct;15(5):377-98. doi: 10.1093/intqhc/mzg049. PMID: 14527982. *Multiple publication_measurement*

7. Ashton T. Measuring health system performance: A new approach to accountability and quality improvement in New Zealand. Health Policy. 2015 Aug;119(8):999-1004. doi: 10.1016/j.healthpol.2015.04.012. PMID: 25979415. *IncludeDE_Framework and Measures*

8. Australian Government. National Health Reform: Performance and Accountability Framework. 2011. https://www.aihw.gov.au/getmedia/ea9b2361-38de-43f3-9426-8705fcc8f1da/performance-and-accountability-framework.pdf.aspx%E2%80%99. *IncludeDE_Framework and Measures*

9. Bardehle D. Minimum health indicator set for South Eastern Europe. Croat Med J. 2002 Apr;43(2):170-3. PMID: 11885042. *IncludeDE_Framework and Measures*

10. Barton MB. An Orientation to NCQA and HEDIS. National Committee for Quality Assurance; 2020. https://www.preventcancer.org/wp-content/uploads/2020/11/Mary-Barton-Session-7-Topic-1.pdf. Accessed on January 15, 2024. *IncludeDE_Framework and Measures*

11. Battelle. Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR) Partnership for Quality Measurement. Columbus, Ohio: September 2023. https://p4qm.org/sites/default/files/2023-09/Guidebook-of-Policies-and-Procedures-for-Pre-Rulemaking-Measure-Review-%28PRMR%29-and-Measure-Set-Review-%28MSR%29-Final_0.pdf. *IncludeDE_Measures*

12. Behrouzi F, Ma'aram A. Identification and ranking of specific balanced scorecard performance measures for hospitals: A case study of private hospitals in the Klang Valley area, Malaysia. Int J Health Plann Manage. 2019 Oct;34(4):1364-76. doi: 10.1002/hpm.2799. PMID: 31025447. *IncludeDE_Measures*

13. Belgian Health Care Knowledge Centre. Performance of the Belgian Health System Report 2012, KCE Report 196c Belgium. 2013. https://kce.fgov.be/sites/default/files/2021-11/KCE_196S3_Health%20system%20performance%20Report%202012_0_1.pdf. *IncludeDE_Framework and Measures*

14. Berg M, Meijerink Y, Gras M, et al. Feasibility first: developing public performance indicators on patient safety and clinical effectiveness for Dutch hospitals. Health Policy. 2005 Dec;75(1):59-73. doi: 10.1016/j.healthpol.2005.02.007. PMID: 16298229. *IncludeDE_Measures*

15. Blozik E, Reich O, Rapold R, et al. Evidence-based indicators for the measurement of quality of primary care using health insurance claims data in Switzerland: results of a pragmatic consensus process. BMC Health Serv Res. 2018 Sep 27;18(1):743. doi: 10.1186/s12913-018-3477-z. PMID: 30261865. *IncludeDE_Measures IncludeDE_Framework and Measures*

16. Braspenning J, Campbell S, Grol R. Measuring changes in patient care: development and use of indicators. In Improving patient care: the implementation of change in clinical practice. In: Grol R, Wensing M, Eccles M, eds. Improving patient care: the implementation of change in clinical practice. Vol. IV. 2005:290. *IncludeDE_Measures*

17. Campbell SM, Kontopantelis E, Hannon K, et al. Framework and indicator testing protocol for developing and piloting quality indicators for the UK quality and outcomes framework. BMC Fam Pract. 2011 Aug 10;12:85. doi: 10.1186/1471-2296-12-85. PMID: 21831317. *IncludeDE_Measures*

18. Campbell SM, Roland MO, Quayle JA, et al. Quality indicators for general practice: which ones can general practitioners and health authority managers agree are important and how useful are they? J Public Health Med. 1998 Dec;20(4):414-21. doi: 10.1093/oxfordjournals.pubmed.a024796. PMID: 9923948. *IncludeDE_Framework and Measures*

19. Canadian Institute for Health Information. The Health Indicators Project: The Next 5 Years Report from the Second Consensus Conference on Population Health Indicators. Ottawa, Canada: 2005. https://secure.cihi.ca/free_products/Consensus_Conference_e.pdf. *IncludeDE_Measures*

20. Canadian Institute for Health Information. Pan-Canadian Primary Health Care Indicators Canadian Institute for Health Information. Toronto: 2006. *IncludeDE_Measures*

21. Carinci F, Van Gool K, Mainz J, et al. Towards actionable international comparisons of health system performance: expert revision of the OECD framework and quality indicators. Int J Qual Health Care. 2015 Apr;27(2):137-46. doi: 10.1093/intqhc/mzv004. PMID: 25758443. *IncludeDE_Framework and Measures*

22. Casey MM, Moscovice I, Klingner J, et al. Rural relevant quality measures for critical access hospitals. J Rural Health. 2013 Spring;29(2):159-71. doi: 10.1111/j.1748-0361.2012.00420.x. PMID: 23551646. *IncludeDE_Measures*

23. Center for Health Policy/Center for Primary Care and Outcomes Research & Battelle Memorial Institute. Quality Indicator Measure Development, Implementation, Maintenance, and Retirement (Prepared by Battelle, under Contract No. 290-04-0020) Agency for Healthcare Research and Quality. Rockville, MD: May 2011. https://qualityindicators.ahrq.gov/Downloads/Resources/Publications/2011/QI_Measure_Development_Implementation_Maintenance_Retirement_Full_5-3-11.pdf?_gl=1*13ar0xb*_ga*MTkyMTUxNTU2NC4xNjk5MDc3Nzk0*_ga_45NDTD15CJ*MTcwMTk5NDUzNy4yLjAuMTcwMTk5NDUzNy42MC4wLjA. *IncludeDE_Measures*

24. Centers for Medicare & Medicaid Services (CMS). Quality Measures Development Overview. n.d. https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/downloads/qualitymeasuresdevelopmentoverview.pdf. *IncludeDE_Measures*

25. Committee on Quality Measures for the Healthy People Leading Health Indicators, Board on Population Health and Health Practice, Institute of Medicine. Toward Quality Measures for Population Health and the Leading Health Indicators. Washington (DC); 2013. *IncludeDE_Framework and Measures*

26. Crampton P, Perera R, Crengle S, et al. What makes a good performance indicator? Devising primary care performance indicators for New Zealand. The New Zealand Medical Journal (Online). 2004;117(1191). *IncludeDE_Measures*

27. Davis P, Milne B, Parker K, et al. Efficiency, effectiveness, equity (E3). Evaluating hospital performance in three dimensions. Health Policy. 2013 Sep;112(1-2):19-27. doi: 10.1016/j.healthpol.2013.02.008. PMID: 23537468. *IncludeDE_Measures* *IncludeDE_Framework and Measures*

28. ECHI working group. Design for a set of European Community Health Indicators: Final report by the EHCI project National Institute of Public health and the Environment (RIVM). Bilthoven, The Netherlands: February 15 2001. https://www.healthinformationportal.eu/sites/default/files/documents/design_for_a_set_of_eur_comm_health_indicators_edm2002_06.pdf. *Multiple publication*

29. Ehreth JL. The development and evaluation of hospital performance measures for policy analysis. Med Care. 1994 Jun;32(6):568-87. doi: 10.1097/00005650-199406000-00003. PMID: 8189775. *IncludeDE_Measures*

30. Etches V, Frank J, Ruggiero ED, et al. Measuring population health: a review of indicators. Annual review of public health. 2006;27(1):29-55. *IncludeDE_Measures*

31. Evans SM, Lowinger JS, Sprivulis PC, et al. Prioritizing quality indicator development across the healthcare system: identifying what to measure. Intern Med J. 2009 Oct;39(10):648-54. doi: 10.1111/j.1445-5994.2008.01733.x. PMID: 19371394. *IncludeDE_Measures*

32. Excellence NIfHaC. NICE indicator process guide. U.K.: December 18, 2019 2019. https://www.nice.org.uk/process/pmg44. *IncludeDE_Measures*

33. Fisher CE, Spaeth-Rublee B, Alan Pincus H. Developing mental health-care quality indicators: toward a common framework. Int J Qual Health Care. 2013 Feb;25(1):75-80. doi: 10.1093/intqhc/mzs074. PMID: 23175534. *IncludeDE_Framework and Measures*

34. Flowers J, Hall P, Pencheon D. Public health indicators. Public Health. 2005 Apr;119(4):239-45. doi: 10.1016/j.puhe.2005.01.003. PMID: 15733682. *IncludeDE_Measures*

35. Gardner K, Mazza D, Gardner K, et al. Quality in general practice - definitions and frameworks. Australian Family Physician. 2012 Mar;41(3):151-4. PMID: 108107065. Language: English. Entry Date: 20120928. Revision Date: 20190912. Publication Type: Journal Article. *Multiple publication*

36. Haj-Ali W, Hutchison B, Primary Care Performance Measurement Steering C. Establishing a Primary Care Performance Measurement Framework for Ontario. Healthc Policy. 2017 Feb;12(3):66-79. PMID: 28277205. *IncludeDE_Framework and Measures*

37. Halliwell A. The Care Quality Commission's new assessment framework. Nursing & Residential Care. 2022;24(9):1-4. doi: 10.12968/nrec.2022.0044. PMID: 159490534. Language: English. Entry Date: 20221013. Revision Date: 20221013. Publication Type: Journal Article. *Multiple publication_framework*

38. Halliwell A. The Care Quality Commission's new single assessment framework. Nursing & Residential Care. 2024;26(2):1-5. doi: 10.12968/nrec.2024.0006. PMID: 175694486. Language: English. Entry Date: 20240301. Revision Date: 20240301. Publication Type: Journal Article. *Multiple publication_framework*

39. Ham C, Raleigh V, Foot C, et al. Measuring the performance of local health systems: a review for the Department of Health. The King's Fund. 2015. *IncludeDE_Framework and Measures*

40. Hatef E, Lasser EC, Kharrazi HHK, et al. A Population Health Measurement Framework: Evidence-Based Metrics for Assessing Community-Level Population Health in the Global Budget Context. Popul Health Manag. 2018 Aug;21(4):261-70. doi: 10.1089/pop.2017.0112. PMID: 29035630. *IncludeDE_Measures*

41. Hearnshaw HM, Harker RM, Cheater FM, et al. Expert consensus on the desirable characteristics of review criteria for improvement of health care quality. Qual Health Care. 2001 Sep;10(3):173-8. doi: 10.1136/qhc.0100173.. PMID: 11533425. *IncludeDE_Measures*

42. Hiltunen KA. HEDIS 1999 effectiveness of care measures: implementation issues. J Healthc Qual. 1999 Sep-Oct;21(5):32-5, 54-5. doi: 10.1111/j.1945-1474.1999.tb00988.x. PMID: 10620883. *Multiple publication to HEDIS*

43. Hurtado MP, Swift EK, Corrigan JM, et al. Envisioning the National Health Care Quality Report. Washington (DC); 2001. *IncludeDE_NHQDR-Framework and Criteria*

44. Institute of Medicine (IOM). Performance Measurement: Accelerating Improvement National Academy Press. Washington, D.C: 2005. *IncludeDE_Framework and Measures*

45. Institute of Medicine Committee on Future Directions for the National Healthcare Quality and Disparities Reports. Future Directions for the National Healthcare Quality and Disparities Reports. In: Ulmer C, Bruno M, Burke S, eds. Washington (DC): National Academies Press (US)

Copyright 2010 by the National Academy of Sciences. All rights reserved.; 2010. *IncludeDE_NHQDR-Framework and Criteria*

46. Irish Department of Health. Health Care Quality Indicators in the Irish Health System: Examining the Potential of Hospital Discharge Data using the Hospital Inpatient Enquiry System An Roinn Slainte Department of Health. Ireland: 2013. http://www.rte.ie/documents/news/hcqi.pdf. *IncludeDE_Measures*

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Appendix C. Evidence Table

Table C.1. Evidence table of identified approaches reporting prioritization criteria for quality of care and care disparities measures

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
AHRQ, 2002[21] US	**Setting:** Inpatient/quality of care in hospitals **Intended use:** AHRQ **Prioritization process:**1. Obtain background information on quality indicator (QI) use 2. Structured literature review to identify potential QIs (search strategy in Medline; title/abstract screening; data abstraction in two stages- first, preliminary abstraction to evaluate each identified article for presence of defined quality indicator, clinical rational, and strengths and weaknesses, and second, to qualify for full data abstraction, articles must have explicitly defined novel quality indicator; team collected information on definition of QI, validation, and rationale during full abstraction 3. Evaluate each potential QI against 6 criteria (face validity, precision, minimum bias, construct validity, fosters real quality improvement, application); Review additional articles to provide evidence on indicators during evaluation phase; Assess link between each indicator and health care quality along 7 dimensions (proxy, selection bias, information bias, confounding bias, unclear construct validity, easily manipulated, unclear benchmark) 4. Perform a comprehensive evaluation of risk adjustment 5. Evaluate indicators using empirical analyses	**Eligibility:** N/A **Nature of the measures:** Process : Esophageal resection volume; Pediatric heart surgery volume,Outcome : Esophageal resection mortality rate; Pediatric heart surgery mortality rate **Criteria definition:** Face validity = sound clinical or empirical rationale for its use; should measure an important aspect of quality that is subject to provider or health system control Precision = have relatively large variation among providers or areas that is not due to random variation or patient characteristics; measures the impact of chance on apparent provider or community health system performance Minimum bias = should not be affected by systematic differences in patient case-mix, including disease severity and comorbidity; in cases where such systematic differences exist, an adequate risk adjustment system should be possible using available data Construct validity = should be related to other indicators or measures intended to measure the same or related aspects of quality Fosters real quality improvement = should be robust to possible provider manipulation of the system (i.e., should be insulated from perverse incentives for providers to improve their reported performance by avoiding difficult or complex cases, or by other responses that do not improve quality of care) Application = should have been used in the past or have high potential for working well with other indicators **Compared to NHQDR:** Both criteria sets include validity, scientific soundness, linkable to establish indicator sets, and improvability. The AHRQ 2002 criteria includes: Relatively large variation among providers or areas that is not due to random variation or patient characteristics; Minimum bias; Have been used in the past or have high potential for working well with other indicators, while the NHQDR does not. The AHRQ 2002 criteria was used to select inpatient/quality of care for hospitals indicators, while the NHQDR criteria is used to select quality of care indicators for healthcare more generally.	Face validity Precision Minimum bias Construct validity Fosters real quality improvement Application

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Context: To select indicators for quality of care for hospital **Engagement:** No Project team **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Unclear Not reported, but this process has been used by AHRQ in previous years	Both frameworks addresses health care delivery in some way.	
AHRQ, 2003[13][1] US	**Setting:** Healthcare quality of care **Intended use:** AHRQ **Prioritization process:**Measures were sorted into the conceptual framework. Using the selection criteria, measures not suitable were eliminated from the measure set. Agencies were given a complete list of the measures and asked to rate their measure submissions and those of others using a structured rating form containing the criteria. Agencies were then asked to submit any additional measures. Following the workgroup's work on the measures, the preliminary measure set was reviewed by internal experts and senior management at AHRQ. It was then presented to reviewers within HHS, including the Quality Interagency Coordination Task Force (QuIC) and the HHS Data Council. External feedback was obtained through two primary vehicles. The first was a hearing sponsored by the National Committee on Vital and Health Statistics in Chicago on July 25, 2002. The second was a call for feedback on the NHQR preliminary measure set in the Federal Register published August 19, 2002. This feedback was synthesized and reviewed by the NHQR Measures Workgroup with the goal of generating necessary	**Eligibility:** N/A **Nature of the measures:** Structure : ED visits: Average time from arrival to being seen by a physician (separately for emergent, urgent, semi- urgent, and non-urgent visits),Process : Screening rates for breast cancer, cervical cancer, colorectal cancer,Outcome : Cancer mortality rates,Patient experience : % of patients who report that doctor spent enough time with them (always, usually, sometimes/never), adults and parents of children **Criteria definition:** Importance = What is the impact on health associated with the health problem assessed by the measure? Are policymakers and consumers concerned about this area of health care quality? Can the health care system meaningfully address this aspect or problem? Scientific soundness = Does the measure actually reflect what it is intended to measure? Does the measure provide stable results across various populations and circumstances? Is there scientific evidence available to support the measure? Feasibility = Is the measure in use? Can information needed for the measure be collected in the scale and time-frame required? How much will it cost to collect the data needed for the measure? Can the measure be used to compare different population groups? All measurement and reporting efforts must strike a balance among the tensions inherent in meeting all three above criteria = N/A Whenever possible, measures presented in this report use assessments of performance that are consistent with current science and supported by professional consensus = N/A **Compared to NHQDR:**	Clinical importance Scientific soundness Feasibility All measurement and reporting efforts must strike a balance among the tensions inherent in meeting all three above criteria Whenever possible, measures presented in this report use assessments of performance that are consistent with current science and supported by professional consensus

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	additions, deletions, and alterations to measures in the measure set. This feedback was then reviewed by the NHQR Measures Workgroup and sorted for action. Action items were then forwarded on to the full NHQR Interagency Workgroup which met on January 10, 2003. The full group made a set of recommendations on the proposed final measure set to AHRQ senior leadership, which reviewed these recommendations on January 21, 2003. Following this review, the measure set for the first NHQR was updated and finalized. **Context:** This criteria have been used to select NHQR measures. **Engagement:** Yes Formal input was received through an Interagency Workgroup and a presentation to the HHS Data Council. **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	Both criteria sets include importance, scientific soundness, and feasibility. This criteria set includes the following two criteria: All measurement and reporting efforts must strike a balance among the tensions inherent in meeting all three above criteria, and Whenever possible, measures presented in this report use assessments of performance that are consistent with current science and supported by professional consensus, while the current NHQDR criteria set does not include them.	
AHRQ, 2003[13][3] US	**Setting:** Healthcare disparities **Intended use:** AHRQ **Prioritization process:** Measures followed two separate pathways for inclusion in this report. First, because this report and the National Healthcare Quality Report (NHQR) are companion documents, NHDR adopted the quality of care measure set for the NHQR in its entirety. In this first edition of the reports, the quality of care measures are identical in both the NHDR and the NHQR except for several measures for which analysis by race/ethnicity and socioeconomic	**Eligibility:** N/A **Nature of the measures:** Structure : Percent of families that experience difficulties or delays in obtaining health care or do not receive needed health care for one or more family members,Process : Cervical cancer screenings,Outcome : Hospital admissions for long term complications of diabetes,Patient experience : % of adults whose providers always showed respect for what they had to say **Criteria definition:** N/A **Compared to NHQDR:** This criteria set includes the following criteria that are not included in the current NHQDR criteria: All measures included in the 2003 NHQR; The selection of measures of disparity in health care to	All measures included in the 2003 NHQR The selection of measures of disparity in health care to include in the first NHDR was guided by two key principles, used whenever possible: Measures developed through consensus processes, whereby experts convene and deliberate with the goal of producing high quality measures Measures consistent with Federal guidelines and publications

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	position was not possible. Second, disparities can exist in many aspects of health care delivery other than quality of care. To compile measures that relate to these other areas where health care disparities exist (i.e., access to care, use of care, and cost of care), AHRQ published a call for measures in the Federal Register on June 5, 2002, and engaged the Institute of Medicine to convene experts to hear public testimony, commission papers, and provide guidance on this report. **Context:** This criteria has been used to select measures for healthcare disparities for the NHDR. **Engagement:** Yes Engaged the Institute of Medicine to convene experts to hear public testimony, commission papers, and provide guidance on the report **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication this has been tested empirically	include in the first NHDR was guided by two key principles, used whenever possible: Measures developed through consensus processes, whereby experts convene and deliberate with the goal of producing high quality measures, and Measures consistent with Federal guidelines and publications.	
AHRQ, 2004[13][2] US	**Setting:** Healthcare disparities **Intended use:** AHRQ **Prioritization process:** N/A **Context:** This criteria have been used to select measures of disparities in the NHDR. **Engagement:** Unclear Not reported **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Process : Adults with diabetes who had a retinal eye examination in past year, Outcome : Infant mortality per 1,000 live births **Criteria definition:** Importance = N/A Scientific soundness = N/A Feasibility = N/A Recency of data = Measures with newer data were favored Proximity of care = Process measures were favored over outcome measures	Importance Scientific soundness Feasibility Recency of data Proximity of care Clinical significance Methodological soundness Prevalence Generalizability Specificity Number of comparisons

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Clinical significance = Measures with greater clinical significance were favored	
		Methodological soundness = Measures with fewer methodological caveats were favored	
		Prevalence = Measures affecting more people were favored over measures affecting fewer people	
		Generalizability = Measures that apply to the general population were favored over measures unique to specific populations	
		Specificity = Measures that are specific for a particular condition were favored over measures that are not specific	
		Number of comparisons = Measures that support more comparisons by race, ethnicity, and SES were favored over measures that support fewer comparisons	
		Compared to NHQDR: Both criteria sets included importance, scientific soundness, feasibility, type of measure (process preferred), and applicability to general population. This criteria set included the following criteria that are not in the current NHQDR criteria set: Measures with newer data; Measures with greater clinical significance were favored; Measures with fewer methodological caveats were favored; Measures affecting more people were favored over measures affecting fewer people; Measures that are specific for a particular condition were favored over measures that are not specific; Measures that support more comparisons by race, ethnicity, and SES were favored over measures that support fewer comparisons.	
AHRQ, 2005[130] US	**Setting:** Healthcare quality of care **Intended use:** AHRQ **Prioritization process:**The 2005 NHDR was planned and written by AHRQ staff with the support of AHRQ's National Advisory Council and the Interagency Work Group for the NHDR. The work group includes representatives from every operating division of the Department of Health and Human Services. In addition, to guide the development of new composite measures and new methods for summarizing report information, a	**Eligibility:** N/A **Nature of the measures:** Process : Receipt of evaluation of left ventricular ejection fraction; recipe of influenza screening or vaccination,Outcome : HIV patients with CD4 cell count <50 who received disseminated Mycobacterium avian complex prophylaxis,Patient experience : Adults whose health providers sometimes or never listened carefully, explained things, showed respect, and spent enough time with them **Criteria definition:** N/A **Compared to NHQDR:**	Primary criteria: Importance/clinical significance/prevalence Reliability of data Ability to track multiple disparities groups at multiple levels/number of comparisons possible Sensitivity to change (evidence-based process measures favored over outcomes) Ease of interpretation and understanding/methodological simplicity High utility for directing public policy

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Technical Expert Panel was convened. This panel included health statisticians and health policymakers from the Federal and private sectors. The Interagency Work Groups established additional criteria for selecting the core report measures. Many of these criteria were based on criteria used to select the Healthy People 2010 Leading Health Indicators as well as criteria used to select measures to highlight in the 2004 reports. **Context:** This has been used to select measures for the NHDR. **Engagement:** Yes The Interagency Work Groups were convened to select a group of measures from the full measure sets on which the reports would present findings each year. The IWG established additional criteria for selecting the core report measures. **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) NHDR specifically addresses populations affected by disparities, but NHQR addresses US population in general **Validity testing status:** Tested The criteria have been used to select measures for the NHQDR	The criteria set includes all current NHQDR criteria, but also includes 'high utility for directing public policy' and 'ability to track multiple disparities groups at multiple levels/number of comparisons possible.	Secondary criteria: Applicability to the general U.S. population Availability of data regularly and recently Ability to link to established indicator sets (i.e., Healthy People 2010 objectives) Ability to support multivariate modeling Balancing criteria across core report measures: Balance across health conditions Balance across sites of care Inclusion of at least some State data Inclusion of at least some multivariate models
AHRQ, 2011[42] US	**Setting:** Healthcare quality of care **Intended use:** AHRQ **Prioritization process:** Literature review to identify candidate indicators, development of conceptual model, expert engagement to help facilitate development of conceptual model to inform entire QI measure development process, assess candidate indicators, second literature review focused on abstraction of evidence supporting indicators, panel review to	**Eligibility:** N/A **Nature of the measures:** Structure : Volume, Process : Procedure utilization, Outcome : No example provided **Criteria definition:** Importance = Is the concept important to measure? Is there opportunity for improvement? Usability = Does the measure foster true quality improvement instead of gaming or adverse consequences? Is the measure harmonized	Importance Scientific acceptability Usability Feasibility

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	assess indicators and primarily address scientific acceptability of indicator, risk adjustment, empirical analyses (1. Initial indicator rates 2. Mean hospital or area level rate and variation 3. Measures of precision including signal ratio 4. Measures of reliability including persistence 5. Relationship between the indicator and other quality indicators; Numerator breakdown, Regression analyses, Impact of definitional changes, Exploration of qualifying cases), finalization of specifications, summary of evidence for each recommended candidate indicator **Context:** Stated that the criteria follows the NQF criteria **Engagement:** Yes Panel for RAND/UCLA method to assess measures **Evidence-based:** Empirically based **Defined population:** No (target unclear) **Validity testing status:** Tested All QI modules are internally and externally tested, including implementation with existing data, to ensure accuracy and consistency. Testing includes identifying and deploying an appropriate test dataset for use with the AHRQ QIs.	with similar measures? Is the measure meaningful, understandable and useful? Feasibility = Does the measure minimize burden? Is the data collection and implementation feasible? Scientific acceptability = Is the measure precisely defined? Is it reliable (test-retest and inter-rater)? Does the measure demonstrate face validity, construct validity, and predictive validity? Is there systematic bias and can that bias be address with adjustment? Does it detect meaningful differences in performance? **Compared to NHQDR:** Both criteria sets include importance, usability, feasibility, scientific soundness, reliability, validity, and improvability. There is not much difference between the two sets.	
AHRQ, 2018[22] US	**Setting:** Healthcare delivery performance **Intended use:** Agency for Healthcare Research and Quality **Prioritization process:**Not reported **Context:** It has been used as inclusion criteria for clinical practice guidelines. **Engagement:** No Suggested by authors **Evidence-based:** No **Defined population:** Yes (framework target described in detail)	**Eligibility:** N/A **Nature of the measures:** Unclear **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets are used to select measures for healthcare delivery performance. There is not much overlap between the two criteria sets. Both framework address healthcare delivery, and include access, effectiveness, timeliness, efficiency, and health systems infrastructure capabilities.	1. Must address some aspect(s) of healthcare delivery or population health that can be classified into one of the NQMC domains 2. Must be in current use or have been pilot tested within the last 3 years and must be the most recent version if the measure has been revised; a measure is in current use if at least one healthcare organization has used the measure to evaluate or report on quality of care within the previous 3 years

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Validity testing status: Not tested No indication that this has been tested empirically		3. The submitter must provide English-language documentation that is available upon request in print or electronic format that includes at least each of the four following items: rationale for the measure; description of the denominator and numerator of the measure; data source(s) for the measure; and documentation of evidence supporting the measure and the criterion of quality is required for Quality Measures, and for the quality component of Efficiency Measures 4. At least one of the following criteria must be satisfied with specific information attached in each case (evidence from peer-reviewed literature is preferred): the measure has been cited in one or more reported in a National Library of Medicine indexed, peer-reviewed journal, applying or evaluating the measure's properties; the submitter provides documented evidence evaluating the reliability and validity of the measure; or the measure has been developed, adopted, adapted, or endorsed by an organization that promotes rigorous development and use of measurement in health care - such an organization may be at the international, national, regional, state or local levels
Al-Gham di, 2023[23] Saudi Arabia	**Setting:** Healthcare quality of care in Saudi Arabia **Intended use:** N/A **Prioritization process:**The initial pool of 2500 + indicators was sourced from the current state assessment and benchmarking report. The indicators were then shortlisted by elimination through following a series of steps as part of the analysis, selection and inclusion process.	**Eligibility:** Alignment with definition **Nature of the measures:** Structure : Hospital stay, Beds,Process : Number of primary health care visits per capita per year,Outcome : Mortality, Quality of life,Patient experience : Overall rating **Criteria definition:** Definition = Indicator definitions/descriptions and methodologies were added based on the data available from the CSA Report, Benchmarking Report, publicly available data, and further engagement with the Steering Committee members; only well-defined indicators were considered.	Definition Alignment Specificity Redundancy Scoring Shortlisting

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	The first step is definition; indicator definitions/descriptions and methodologies were added based on the data available from the CSA Report, Benchmarking Report, publicly available data, and further engagement with the Steering Committee members; only well-defined indicators were considered. The second step is alignment; upon defining the frameworks' subdomains, a mapping exercise was conducted to align the indicators with their relevant subdomain, and indicators which were not aligned with the subdomains were removed from the indicator pool. The third step is specificity; indicators that were too specific to be measured at a national level in KSA, either due to being too operational or only relevant to its sourced entity/country, were removed from the indicator pool. The fourth step is redundancy; to be parsimonious, indicators that were identical in definition or very similar in nature were removed, considering only one of the indicators and, if possible, prioritizing indicators sourced from either KSA National bodies or global health organizations. The fifth step is scoring; based on the scoring exercise conducted through engagement with the project's SMEs, including local experts from the steering committee, indicators that scored 4 and above (unless qualified as an exception) were considered for inclusion within the framework. The final step is shortlisting; a list of indicators was finally shortlisted in the frame- work as an output of the team's analysis and selection process while accounting for feedback from the Steering Committee members (where possible).	Alignment = Upon defining the frameworks' subdomains, a mapping exercise was conducted to align the indicators with their relevant subdomain, and indicators which were not aligned with the subdomains were removed from the indicator pool. Specificity = Indicators that were too specific to be measured at a national level in KSA, either due to being too operational or only relevant to its sourced entity/country, were removed from the indicator pool. Redundancy = To be parsimonious, indicators that were identical in definition or very similar in nature were removed, considering only one of the indicators and, if possible, prioritizing indicators sourced from either KSA National bodies or global health organizations. Scoring = Based on the scoring exercise conducted through engagement with the project's SMEs, including local experts from the steering committee, indicators that scored 4 and above (unless qualified as an exception) were considered for inclusion within the framework. Shortlisting = A list of indicators was finally shortlisted in the framework as an output of the team's analysis and selection process while accounting for feedback from the Steering Committee members (where possible). **Compared to NHQDR:** Both criteria sets include applicability to the general population and "at least some data." The Saudi Arabia criteria set included: Alignment with quality of care domains in the framework; Not redundant with other indicators; Had to score higher than 4 (but no explanation of how it was scored), while the NHQDR does not. Both frameworks address health care/health system, and include safety, effectiveness, access, and care coordination.	

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	The team reviewed the indicators from the pool of indicators sourced from the current state assessment and benchmarking report, and mapped relevant indicators to the subdomains which are aligned with their definition. Selection criteria and a rubric against which the mapped indicators were scored, were set in alignment with the design principles **Context:** N/A **Engagement:** Yes Input on designing the framework **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that the model has been tested empirically		
Ashton, 2015[26] New Zealand	**Setting:** New Zealand health system performance (first year only applies to primary health care services, but will continue to be developed over time and extend to cover wide range of health and disability services) **Intended use:** New Zealand Ministry of Health **Prioritization process:**Measures within the IPIF will be set at two levels: the system level, where measures are set nationally, and the local district level, where contributory measures will be selected by local alliances between District Health Boards, Primary Health Organizations and other key stakeholders. The idea is that, for each system level measure, each district must select from a common library a set of contributory measures that contributes to the system level measure, meets the needs and priorities of their local community, and is	**Eligibility:** N/A **Nature of the measures:** Structure : Standardized number of acute inpatient bed days per capita,Process : Increase immunization,Outcome : Healthy child **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include applicability to the general population, improvability, value, and population equity. The criteria in this study also includes Improving the quality, safety, and experience of care, while the NHQDR does not. Both frameworks include equity, value, safety, types of care, access, and health systems infrastructure capabilities. Effectiveness is arguably implicitly included in the IPIF under the 'improved health and equity for all populations' component.	Improving health and equity for all populations Getting greater value for public health resources Improving the quality, safety and experience of care

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	agreed by a local alliance of professional and community representatives. For example, a system level measure may aim to reduce adverse events while potential contributory measures might include reducing hospital acquired infections or increasing medication management in pharmacies and general practice. System level measures will apply equally to all districts and will include targets against which overall performance can be measured. In contrast, contributory measures will be used to measure quality improvement within and across local organisations and practices. The process of monitoring changes in system level and contributory measures will be undertaken by a range of different methods including annual reporting requirements, monitoring of contrac- tual agreements, audit, surveys, self-assessment and peer review. **Context:** N/A **Engagement:** Yes Measures within the IPIF will be set at two levels: the system level, where measures are set nationally, and the local district level, where contributory measures will be selected by local alliances between DHBs, PHOs and other key stakeholders. **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically		
Bardeh le, 2002[28]	**Setting:** Public health, health policy and health reporting **Intended use:** Public health for the countries of South Eastern Europe	**Eligibility:** N/A **Nature of the measures:** Structure : Number of primary health care units per 100,000 population,Outcome : Life births (%) weighing 2,500 g and more	Relevant (regarding priorities) Valid (regarding determinants of health) Measurable (in quantitative or qualitative terms)

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Multiple countries	**Prioritization process**:The Health for All 21 (HFA 21) structure was used for the Minimum Indicator Set. The main source of indicators was therefore the list of 224 indicators of the World Health Organization (WHO) HFA 21 strategy. The indicators had to cover socio-demographic and economic situation; mortality; morbidity (hospital discharges); risk factors and lifestyles; environmental health; health care resources, utilization, and costs; and maternal and child health. The preference was to define at least one indicator for each of the topics, taking into account as much as possible the deterioration of health statistics during the 1990s in most SEE countries. Selection criteria for health indicators should be relevant (regarding priorities), valid (regarding determinants of health), measurable (in quantitative or qualitative terms), sensitive (to change and differences), comparable (inter-territorial), repeatable (for time series), affordable (in terms of relative costs), and useful (for intervention). **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include reliability, validity, importance, feasibility, and improvability. The South Eastern Europe criteria set includes: Sensitive to change and differences; Comparable (inter territorial); Represent either a dimension determining health (e.g., economics, or to satisfy different stakeholders (primary and secondary)), while the NHQDR does not. Both frameworks include health care resources as a domain. The South Eastern Europe framework includes mortality-based indicators and morbidity and hospital discharges, which in a way addresses effectiveness (the 2010 NASEM framework includes the domain e	Sensitive (to change and differences) Comparable (inter-territorial) Repeatable (for tine series) Affordable (in terms of relative costs) Useful (for intervention) Represent either a dimension determining health (e.g., economics, or to satisfy different stakeholders (primary and secondary))
Barton, 2020[29] US	**Setting:** Health care quality **Intended use:** NCQA **Prioritization process**:1. Selection is informed by research, policy issues, and emerging priorities; conduct an environmental scan (review guidelines,	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported in this document **Criteria definition:** Relevance = meaningful to stakeholders, important to enhanced	Relevance Scientific soundness Feasibility

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	evidence, and consult stakeholders), prioritize measure concepts	health, financial impact of improvement, controllable, potential for improvement, substantial variation	
	2. Development is an iterative process and includes stakeholder consensus throughout; assess feasibility (availability of data, burden), evaluate importance (gap in quality), drat specifications (outline measure components), testing to assess scientific soundness	Scientific soundness = based on best available evidence, process or structural measures are linked to outcomes, accurate-reliable-valid

Feasibility = precisely specified, needed data available, cost of data collection is reasonable, auditable | |
| | 3. Public comment - every new and reevaluated measure is included in the HEDIS public comment period held annually from Feb-March; stakeholders participating include health plans, clinicians, specialty groups, consumers, policy makers, advocacy groups; feedback includes relevance and importance, feasibility and burden, technical specification details, global measure development comments | **Compared to NHQDR:**
Both criteria sets include relevance, scientific soundness, feasibility, reliability, validity, and improvability. NHQDR has other criteria that are not in the NCQA HEDIS criteria.
Both frameworks include effectiveness, access, care coordination, and types of care. | |
	4. First year - all first year measures are evaluated for suitability for public reporting (works as designed, reporting feasibility, variation in performance)		
	5. Public reporting - performance data for measures approved by the CPM for public reporting will be made available starting the following year (stakeholders are notified during the October Technical Update; results are made available on NCQA's Quality Compass and incorporated into NCQA's Health Plan Ratings		
	6. Evaluation - measures are periodically evaluated for updates or changes; review updates to guidelines or changes within the healthcare delivery system, review feedback received from the Policy Clarification Support system, solicit feedback from panels, public stakeholders, Federal partners and		

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	measure users, analyze historic performance results 7. Ongoing use - ongoing maintenance ensures that measures remain current and appropriate for continued use; review of codes, drugs and NDC listed by NCQA panels; update models used for risk adjustment (HCCs, CCs); review feedback/comments from the field (Policy Clarification Support System, HEDIC user group) 8. Retirement - the decision to retire a measure is informed be several factors: continued relevance and importance, has the quality gap closed, better measures available **Context:** To develop measures for HEDIS **Engagement:** Yes Feedback on measure development **Evidence-based:** No **Defined population:** Unclear NCQA addresses US population, but it doesn't explicitly report the population **Validity testing status:** Tested HEDIS is a well known measure set and the criteria although constantly changing has been applied in context		
Batelle, 2023[30] US	**Setting:** Healthcare quality **Intended use:** CMS **Prioritization process:**Pre-Rulemaking Measure Review (PRMR; measure inclusion): Information Collection: measure list published, preliminary assessment published, setting-specific advisory group and setting specific recommendations group; Analysis and Feedback: public comment, round 1 evaluation (pre-vote to identify	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported **Criteria definition:** Meaningfulness = measure is evaluated and tailored to unique needs of specific program-target population Appropriateness of scale = measure portfolio is balanced and scaled to meet target program- and population-specific goals, specifically, measure is evaluated in the context of all the measures currently within the program measure portfolio	Pre-Rulemaking Measure Review: Meaningfulness Appropriateness of scale Time to value realization Measure Set Review: Impact Clinician data streams Patient journey

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	areas of disagreement), Q&A session and public comment, round 1 evaluation completed and returned to recommendation group, commentary compiled and published; Discussion and Recommendation: recommendation group meeting for final evaluation (vote on consensus on recommendations to CMS), recommendations submitted to CMS, public comment Measure Set Review (MSR; measure removal): Selection of Measures: review calendar of cascade, select 30 to review, CMS review, public comment, finalize measures for review; Analysis and Feedback: conduct additional assessments, engage CMS programs, conduct additional expert interviews, compile all assessments into a report, public comment, post report to website, send report to MSR group for preliminary ratings, process public comment and MSR group rating; Discussion and Recommendation: MSR meeting, final recommendation **Context:** This process is used yearly by HHS CMS on the selection of quality and efficiency measures under consideration for use by HHS, and to provide recommendations on the removal of measures for CMS programs. **Engagement:** Yes Hybrid Delphi and Nominal Group technique; multi-step review; meaningful opportunities for public engagement; rural health and health equity expertise embedded into the committees; patients'/recipients of care and caregivers' voices	Time to value realization = measure has plan for near- and long-term positive impacts on the targeted program and population as measure matures Impact = measure set evaluated across program, target population, and time Clinician data streams = measure set redundancy in data streams is identified and mitigated, specifically by evaluating the burden associated with reporting the measure, considering other related measures Patient journey = measure set redundancy is identified and mitigated, specifically, by evaluating if the measure addresses the right aspect of care, in the right setting, and at the right point in a patient's journey to maximize the desired outcome **Compared to NHQDR:** Both criteria sets include importance (meaningfulness and impact), feasibility, applicability to the general population, and improvability. The HHS/CMS criteria also includes: "Appropriateness of scale (balanced and scaled to meet target program- and population-specific goals)" and "Measure set redundancy is identified and mitigated, specifically, by evaluating if the measure addresses the right aspect of care, in the right setting, and at the right point in a patient's journey to maximize the desired outcome", while the NHQDR does not.	

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Evidence-based: Empirically based **Defined population:** Yes (framework target described in detail) The general population **Validity testing status:** Tested This process has been used for years		
Behrou zi, 2019[31] Other	**Setting:** Hospital performance **Intended use:** N/A **Prioritization process:**Identify and rank a specific set of performance measures that are feasible and relevant for private hospitals. Forty-four health care performance measures in four bal- anced scorecard (BSC) performance perspectives (financial, customer, internal business processes, and learning and growth) were compiled and filtered based on "feasibility" and "relevance" criteria using a questionnaire survey in private hospitals in the Klang Valley area, Malaysia. Next, the 31 performance measures went through a ranking survey in Klang Valley private hospitals. Therefore, a weight between 0 and 1 with a range of 0.095 to 0.207 was obtained for each performance measure to help hospitals quantify their overall performance more accurately. **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** Empirically based **Defined population:** No (target unclear) **Validity testing status:** Tested Applied to a different context in this article	**Eligibility:** N/A **Nature of the measures:** Structure : average profit per hospital bed, asset turnover,Outcome : patient mortality rate,Patient experience : number of patient complaints **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include feasibility and importance. This criteria set includes: balanced scorecard performance perspectives: financial, customer, internal business processes, and learning and growth, while the NHQDR does not.	Balanced scorecard performance perspectives: Financial Customer Internal business processes Learning and growth Balanced scorecard performance perspectives were compiled and filtered based on feasibility and relevance criteria
Belgia n Health Care Knowl	**Setting:** Belgium health system performance **Intended use:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure : Number of professionals/organizations involved in care,Process : Screening of psychiatric patients for substance use disorders,Outcome : Prevalence alcohol/substance abuse; relapse or recurrent during	Validity Reliability Importance/relevance Interpretability Actionability

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
edge Center, 2013[32] Belgium	**Prioritization process:**Literature review (searched for published indicators); extraction and selection of the indicators **Context:** N/A **Engagement:** Yes Federal Public Service Public Health, Federal Public Service Social Affairs, NIHDI, Scientific Institute of Public Health; and several other organizations were consulted throughout the duration of this project **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	follow-up,Patient experience : Consumer/family satisfaction with services received **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include validity, reliability, and importance. The criteria set for the Belgian health system includes interpretability and actionability, while the NHQDR does not. Both frameworks addresses healthy system delivery, and include the access, effectiveness, safety, efficiency, patient-centeredness, and continuity of care.	
Berg, 2005[33] Netherlands	**Setting:** Public performance indicators on patient safety and clinical effectiveness in Dutch hospitals **Intended use:** Dutch Health Care Inspectorate **Prioritization process:**Create a 'screening' instrument for the Inspectorate of the quality of are delivered in individual care providers; enhance the transparency of the hospital sector; stimulate individual hospitals to improve their scores through the 'burning platform' effect, while keeping the hospitals and professionals on board. **Context:** Hospitals have used these; in October, a pilot was undertaken, in which six hospitals volunteered to test the indicators, and attempted to deliver the requested information in a 1-month period. **Engagement:** Yes the Inspectorate's aim and planned approach was presented to a selection of stakeholders (special- ists, hospital managers, their organizations,	**Eligibility:** N/A **Nature of the measures:** Structure : availability regional medication overview,Process : percent of post-operative patients having received standardized pain measurements,Outcome : point prevalence pressure ulcers **Criteria definition:** Outcome indicator or 'proxy' outcome indicator = When no outcome indicators were available, process or structure indicators with a direct or proven relationship with outcomes were selected Prevalence of the issue = Indicators were preferred that focussed on issues with a high prevalence in order to obtain relevant areas for quality improvement Significant potential improvement of quality = Indicators were selected that focused on areas where variety in current quality provided was large, and the potential for improvement was significant Clear and timely connection with care activities = N/A Causing desirable outcomes = Indicators were selected so as to minimize obvious 'perverse effects' or gaming Administrative ease of implementation = N/A **Compared to NHQDR:**	1) Outcome indicator or 'proxy' outcome indicator 2) Prevalence of the issue 3) Significant potential improvement of quality 4) Clear and timely connection with care activities 5) Causing desirable outcomes 6) Administrative ease of implementation

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	the Min- istry, and so forth) during a so-called 'expert meeting' in April. A second expert meeting, with a s **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested 6 hospitals volunteer to test the indicators, and attempted to deliver the requested information in a 1-month period	Both criteria sets include importance, feasibility, and improvability. The criteria in this study included "When no outcome indicators were available, process or structure indicators with a direct or proven relationship with outcomes were selected", "Clear and timely connection with care activities", and "Indicators were selected so as to minimize obvious 'perverse effects' or gaming", while the NHQDR does not.	
Blozik, 2018[34] Switzerland	**Setting:** Ambulatory primary care **Intended use:** N/A **Prioritization process:** Step 1: Extraction of guideline recommendations and pre-existing QI: primary care guidelines published the German Association of Primary Care and Family Medicine; German National Disease Management Guidelines; German quality indicators for ambulatory care QiSA developed by the AQUA Institute Step 2: Preselection of potential QI that can be principally build based on Swiss health insurance claims data: exclusion of items for which clinical information is systematically not reported to health insurances or the service at interest is not part of the benefit catalogue covered by the Swiss statutory health insurance Step 3: Rating of potential QI by a multidisciplinary group of experts (primary care, public health, academics, health economics) including patient representatives. Rating will be done based on explicit criteria: relevance for public health, clarity of definition, influence on measured aspect of care, risk of undesired effects, strength of evidence Step 4: Face-to-face meeting for discussion of rating round and consensus	**Eligibility:** N/A **Nature of the measures:** Structure : number of different primary care physicians consulted by an individual insured person, Process : proportion of insured persons with anti diabetic medication receiving which HbA1c controls (number of controls per year), Outcome : proportion of insured persons with hospitalization for myocardial infarction receiving acetylsalicylic acid **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance, scientific soundness, usability, and sound measure available. This criteria set includes "risk of undesired effects", while the NHQDR criteria set does not. Both frameworks address quality of care, and includes efficiency, as well as safety in some way (drug safety specifically in this framework).	Relevance for public health Clarity of definition Influence on measured aspect of care Risk of undesired effects Strength of evidence

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	on preliminary set of QI qualifying for feasibility testing Step 5: Feasibility test based on claims data of persons with basic mandatory health insurance at the Helena Group Step 6: 2nd face-to-face meeting to discussion of feasibility test and consensus on the final set of QI **Context:** N/A **Engagement:** Yes Multidisciplinary group of 9 independent experts from primary care, public health, and health economics including patient and consumer representatives rated the list of potential QIs **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically		
Braspenning, 2005[35] Multiple countries	**Setting:** Healthcare quality of care **Intended use:** N/A **Prioritization process:**Not reported. Pulled from existing literature. **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication that this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Structure : Number of professionals (full time equivalents) per 1000 patients,Process : Referral rates; Vaccination rates,Outcome : Post-operative wound infection rates **Criteria definition:** Validity = Content and construct validity Reliability = Test-retest procedure (e.g., inter and intra-rater reliability Sensitivity to change = Capture changes in behavior or setting (e.g., time series and longitudinal analyses) Acceptability = Accept indicator as being relevant and valid measurements for quality of care Feasibility = Depends of data collection depends on the data source Simple and communicable = Communicated easily and understood by the target group enhances acceptance and application **Compared to NHQDR:**	Validity Reliability Sensitivity to change Acceptability Feasibility Simple and communicable

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Both criteria sets include validity, reliability, and feasibility. The criteria in this paper includes sensitivity to change, acceptability, and simple and communicable, while the NHQDR does not.	
Campbell, 1998[37] UK	**Setting:** General practice quality of care **Intended use:** Health authorities for general practice **Prioritization process:**A national survey of health authorities was carried out to identify quality indicators being proposed for use in general practice. A two-stage Delphi process was used to establish general practitioners' (GPs') and health authority managers' views on the face validity of identified indicators. In the first round, respondents were asked to rate the validity and clarity of each indicator. Each attribute was measured on a nine-point scale. After the first round, 62 indicators which failed to meet a pre-set median score of six for validity was removed, and where the respondents had indicated that the meaning of indicators was unclear, authors clarified or reformulated some of the remainder. Indicators which were statutory requirements were also excluded as they were not likely to be discriminating measures of quality. Panelists were given feedback on their validity scores in round 1, and asked to re-rate the indicators in round 2 for validity, reliability, and accessibility, again on separate nine-point scales. **Context:** N/A **Engagement:** Yes ality indicators being proposed for use in general practice. A two-stage Delphi process was used to establish general practitioners' (GPs') and health authority managers' views on the face validity of identified indicators. **Evidence-based:** Empirically based	**Eligibility:** N/A **Nature of the measures:** Structure : A member of the practice staff is available to answer the phone between 9am-5pm on weekdays,Process : Target population screened for cervical cancer **Criteria definition:** Validity = Validity was defined as meaning the indicator measured quality of general practice care as defined for the relevant domain Reliability = A reliable indicator was defined as one for which the information required to apply the indicator was likely to be collected and applied in the same way by different users over time, and to be relatively error free Clarity = Clarity was defined as meaning the indicator was expressed in clear, precise and unambiguous language Accessibility = Accessibility was defined in terms of whether the information would be available currently or could potentially be collected easily **Compared to NHQDR:** Both criteria sets include validity and reliability. The criteria in this study includes clarity and accessibility, while the NHQDR does not. Both frameworks address health care delivery in some way, and include access, health systems capabilities infrastructure, safety, effectiveness, efficiency, timeliness, and types of care.	Validity Reliability Clarity Accessibility

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Defined population: Yes (framework target described in detail) UK general practice **Validity testing status:** Not tested No indication that this has been tested empirically		
Campbell, 2011[36] UK	**Setting:** Healthcare quality of care **Intended use:** N/A **Prioritization process:**1. Collation of information based on NICE guidelines and including suggestions from a range of UK based stakeholders including patient groups and the Department of Health 2. Prioritisation by NICE QOF Advisory Committee: Identification of areas for indicator development and piloting 3. Testing Protocol: Stage 1: Indicator development; Stage 2: Indicator piloting 4. Indicator development - RAND Appropriateness Method, to test for: Clarity, Validity (face and content) 5. Indicator piloting - Recruitment of nationally representative samples of practices: 4 cohorts of 30 practices in England (n=120 in total) on a 6-monthly rotational basis. 2 Practices in Northern Ireland, Scotland and Wales in each cohort respectively. 6. 6 month piloting period 7. Baseline data extraction 8. Final data extraction after 6 month piloting period, to test for: Feasibility, Reliability 9. Interviews with GPs, nurses and other staff after 6 months piloting period, to test for: Acceptability, Implementation issues 10. Piloting recommendations fed back to NICE QOF Advisory Committee to decide	**Eligibility:** N/A **Nature of the measures:** Structure : The percentage of patients on the palliative care register who have a preferred place to receive end-of-life care documented in the records,Outcome : The percentage of patients with diabetes with a record of testing of foot sensation using a 10 g monofilament or vibration (using biothesiometer or calibrated tuning fork), within the preceding 15 months **Criteria definition:** Clarity = RAND appropriateness method ratings Necessity = RAND appropriateness method ratings Validity (face and content) = N/A Feasibility = 'technically feasibility' in current family practice systems and whether supported by current methods of data extraction for QOF (data extraction in all family practice clinical systems) Reliability = reproducible in testing (data extraction: test-retest) Cost effectiveness = summary of evidence of cost effectiveness (cost-effectiveness modeling) Acceptability = risks, issues, relative impact, and uncertainties (interviews with practice staff) Implementation issues = baseline and potential change in baseline; evidence of sensitivity to change (data extraction); excepting reporting/gaming (interviews with practice staff); changes in practice organization, potential barriers, workload (interviews with practice staff and workload diaries); unintended consequences (interviews with practice staff) **Compared to NHQDR:** Both criteria sets include reliability, validity, importance, feasibility, and usability. This criteria set includes: Acceptability; Implementation issues, while the NHQDR does not.	Clarity Necessity Validity (face and content) Feasibility Reliability Cost effectiveness Acceptability Implementation issues

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	whether the indicators go forward to the next stage. 11. Validation and publication by NICE on NICE national menu of indicators **Context:** N/A **Engagement:** Yes RAND/UCLA appropriateness method **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Tested Authors tested the protocol		
Canadian Institute for Health Information, 2005[38] Canada	**Setting:** Healthcare quality of care **Intended use:** Canadian Institute for Health Information **Prioritization process:**Phase I: Identification of information gaps: In the summer of 2003, representatives from health regions were surveyed about the most pressing issues in their jurisdictions and asked for feedback on the types of indicators that could be developed to monitor these concerns. Phase II: Validation of the core set of indicators and identification of potential new indicators: Based on the results of the Phase I survey, a questionnaire was sent to stakeholders seeking advice on the indicator set available at that time and the prioritization of potential new indicators. The results of this survey were used as a basis for discussions at the consensus conference. Phase III: The Second Consensus Conference on Population Health Indicators. Using the information obtained from Phases I and II, an agenda for a second consensus conference was drawn up with an emphasis on achieving agreement in areas where divergent views	**Eligibility:** N/A **Nature of the measures:** Outcome : BMI, infant mortality, low birth weight **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include feasibility. The CIHI criteria set includes relevant to established health goals, based on agreed upon benchmarks/guidelines, and collected using standard methods/definitions and reliable sources, while the NHQDR sets do not.	Relevant to established health goals Based on agreed upon benchmarks/guidelines Collected using standard methods/definitions and reliable sources Feasible at the health region level

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	emerged from the Phase II questionnaire. Additionally, since the equity dimension was added to the framework after the 1999 consensus conference, time was set aside to explore this concept and how it could be measured. **Context:** To identify indicators that could be used to report on the health of Canadians and the health system. **Engagement:** Yes Reported in Measure Prioritization Process field above **Evidence-based:** No **Defined population:** Yes (framework target described in detail) Canadian population health **Validity testing status:** Not tested No indication that the criteria has been tested empirically		
Canadian Institute for Health Information, 2006[39] Canada	**Setting:** Primary health care quality of care **Intended use:** Canadian Institute for Health Information **Prioritization process:**Environmental Scan: National and international documents on PHC frameworks and indicators were reviewed in order to develop a preliminary list of indicators; Two Consensus Conferences: Over 80 policy makers, providers, researchers and system managers participated in consensus conferences to review potential indicators; Working Group: More than 60 policy makers, providers, research and system managers participated in refining the indicators and developing technical specifications; Pan-Canadian/International Consultations: Throughout the process, additional input was collected through consultations with provincial/territorial and regional	**Eligibility:** N/A **Nature of the measures:** Structure : Difficulties accessing routine PHC; PHC after hours coverage,Process : Health risk screening; cancer screening,Outcome : Smoking rate, overweight rate,Patient experience : Satisfaction with wait times for routine PHC **Criteria definition:** Face validity = N/A Measurability = N/A Reliability and comparability = N/A Rationale and importance = N/A Evidence/policy based: Clinical indicators--Grade A and B; System indicators--Grade A and B evidence, systematic literature reviews, NES Objectives, and expert consensus = N/A Future oriented = not limited to what is currently measurable Coverage = there is coverage and balance across the National Evaluation Strategy Objectives and Supports	Face validity Measurability Reliability and comparability Rationale and importance Evidence/policy based: Clinical indicators--Grade A and B; System indicators--Grade A and B evidence, systematic literature reviews, National Evaluation Strategy Objectives, and expert consensus Future oriented Coverage Comparable Broadly applicable Flexible

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	stakeholders, professional health associations, and international researchers; Delphi Process: Over 70 individuals participated in each of the three rounds of a modified Delphi process to rate the indicators for importance. **Context:** N/A **Engagement:** Yes Policy makers, providers, researchers and system managers reviewed potential indicators and refined indicators and developed technical specifications; additional input through consultations with provincial/territorial and regional stakeholders, profession **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically.	Comparable = can be used to compare primary health care across the country and over time Broadly applicable = can be used and applied at multiple levels Flexible = does not restrict what other indicators are developed by jurisdictions to measures additional aspects of PHC **Compared to NHQDR:** Both criteria sets include reliability, validity, importance, scientific soundness, and sound measure available. The Pan-Canadian criteria set includes: Future oriented; There is coverage and balance across the National Evaluation Strategy Objectives and Supports; Flexible; Can be used and applied at multiple levels, while the NHQDR does not.	
Carinci, 2015[40] Kelley and Hurst, 2006[67] Multiple countries	**Setting:** OECD member countries health system performance **Intended use:** Organization for Economic Cooperation and Development **Prioritization process:** A structured assessment was carried out using a modified Delphi approach, which included a review of the evidence on quality indicators conducted by a panel of five experts, two rounds of ratings according to predefined criteria and a final consensus meeting, followed by a consensus meeting, to assess the suite of health care quality indicators for international comparisons, agree on revisions to the original framework and set priorities for research and development. **Context:** N/A	**Eligibility:** N/A **Nature of the measures:** Process : Mammography screening in women aged 50-69; cervical cancer screening in women aged 20-60,Outcome : Postoperative wound dehiscence,Patient experience : Regular doctor spending enough time with patients during the consultation; regular doctor giving opportunity to ask questions or raise concerns; **Criteria definition:** Validity = Sufficient scientific evidence exists to support a link between the value of an indicator and one or more aspects of health care quality Reliability = Repeated measurements of a stable phenomenon get similar results Relevance = An indicator measures an aspect of quality with high clinical importance, a high burden of disease or high health care use Actionability = An indicator measures an aspect of quality that is subject to control by providers and/or the health care system and is	Validity Reliability Relevance Actionability International feasibility International comparability

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Engagement: Yes Meetings to discuss original framework and any updates **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied to different context	actually used at a national level for policy making, monitoring or strategy development International feasibility = An indicator can be derived for international comparisons without substantial additional resources International comparability = Reporting countries comply with the relevant data definition and where differences in the indicator values between countries reflect issues in quality of care rather than differences in data collection methodologies, coding or other non-quality of care reasons **Compared to NHQDR:** Both criteria sets include validity, reliability, importance/relevance, usability/actionability, and feasibility/international feasibility. The OECD criteria set includes international comparability, while the NHQDR does not. Both frameworks addresses healthcare, include the components access, effectiveness, safety, patient centeredness, and efficiency, and have equity as a cross cutting dimension. Both frameworks includes types of care in some way.	
Casey, 2013[41] US	**Setting:** Rural critical access hospital quality of care **Intended use:** N/A **Prioritization process:**The multifaceted approach used to select the relevant quality measures for CAHs included a review of previously identified rural relevant measures, input from a national meeting on quality metrics for small rural hospitals organized by the National Rural Health Association for the federal Office of Rural Health Policy in January 2010, and analysis of several sets of measures being used for national quality improvement, public reporting, and payment reform initiatives. Volume data came from Hospital Compare, the Agency for Healthcare Research and Quality's (AHRQ's) Healthcare Cost and Utilization Project, and the research literature. Information on	**Eligibility:** N/A **Nature of the measures:** Structure : Responsiveness of hospital staff,Process,Patient experience : Overall rating of hospital **Criteria definition:** Volume of the condition(s) addressed by the measure in critical access hospitals = N/A Internal usefulness for quality improvement = N/A External usefulness for public reporting and payment reform = N/A **Compared to NHQDR:** Both criteria sets includes usability/ usefulness. The rural critical access hospitals criteria sets includes: volume of the condition(s) addressed by the measure in critical access hospitals; internal usefulness for quality improvement; external usefulness for public reporting and payment reform, while the NHQDR does not.	Volume of the condition(s) addressed by the measure in critical access hospitals Internal usefulness for quality improvement External usefulness for public reporting and payment reform

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	the internal and external usefulness of the measures came from the research literature; published reports and websites of entities involved in hospital regulation, accreditation and voluntary quality measurementefforts (eg, CMS, the Joint Commission and NQF); and a 6-member expert panel. During an in-person meeting in July 2011, the panel members evaluated the relevance of the potential measures using the 3 criteria, voted whether or not to include each measure on the list of relevant measures, and provided written comments about their choices. The final measures selected had a majority of votes. **Context:** N/A **Engagement:** Yes 6 member expert panel (MD, board certified family physician who has been in practice for over 30 years in a small rural community in South Dakota; President and CEO of Stratis Health, Minnesota's Quality Improvement Organization; RN who has over 25 yrs of **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) Rural critical access hospitals **Validity testing status:** Not tested No indication that the criteria set has been tested emprirically		
CMS, 2022[43] US	**Setting:** Reporting Hospital Quality Data for Annual Payment Update; Physician Quality Reporting Initiative **Intended use:** CMS **Prioritization process:** It begins with the definition of a topic and the empanelling of a topic-specific TEP. With the guidance of	**Eligibility:** N/A **Nature of the measures:** Structure : No example, but listed as one of the types of measures,Process : No example, but listed as one of the types of measures,Outcome : No example, but listed as one of the types of measures,Patient experience : No example, but listed as one of the types of measures	Physician Quality Reporting Initiative: Satisfy statutory requirements for selection Are functional Increase opportunities for eligible professionals to participate in the

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	the TEP, the measure developer develops a measure framework, identifies candidate measures, and provides these measures, accompanied by general information, to the TEP for review. After the TEP reviews the candidate measures list, it is submitted to CMS for review and approval, and public comment may be solicited. Measures approved by CMS at this stage move forward to the specification-development stage. Once specifications have been created for the measures, they are approved by CMS, the measures are tested for both reliability and feasibility, and public comment is solicited. Refinements may be made to the measures at this point, based on public feedback, and they will go through a final approval process and then be submitted for consensus endorsement (e.g., to the NQF). **Context:** This is the 2009 version of CMS' measure development process, which has been used in previous years to develop measures for various CMS initiatives and programs (e.g., physician measures - Physician Quality Reporting Initiative). **Engagement:** Yes Technical Expert Panel whose responsibility it is to provide expert guidance to both CMS and the measure developer and a Measure Developer (e.g., PCPI or NCQA) works together with CMS to develop a standardized approach for the development and maintenance **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Unclear No indication that this has been tested empirically, but CMS' process has been	**Criteria definition:** Satisfy statutory requirements for selection = the measure was developed using a consensus-based process Are functional = i.e. usable Support CMS priorities = e.g., prevention, chronic condition, high-cost and high-volume conditions, improved care coordination Use measures that are based on currently reported data = i.e., to clinical data registries or all-payer claims databases) or that do not require chart abstraction **Compared to NHQDR:** Both criteria sets include usability and type of measure (CMS: process, outcome, structure, patient experience). The CMS set also includes: Satisfy statutory requirements for selection (i.e., the measure was developed using a consensus-based process); Increase opportunities for eligible professionals to participate in the program or apply to an area without applicable measures; Align with other CMS program health care goals; Support CMS priorities (e.g., prevention, chronic conditions, high-cost and high-volume conditions, improved care coordination); Expand measures beyond process measures, to measures of outcome, patient perspectives, and efficiency; Expand the scope of hospital services to which the measures apply; Consider the burden on hospitals; Harmonize the measures with other CMS quality programs; and Weigh the relevance and utility of the measures compared to the burden on hospitals, while the NHQDR does not.	program or apply to an area without applicable measures Align with other CMS program health care goals Support CMS priorities Address various aspects of clinical care, including process, outcome, structure or patient experience Reporting Hospital Quality Data for Annual Payment Update: Satisfying statutory requirements Expand measures beyond process measures, to measures of outcome, patient perspectives, and efficiency Expand the scope of hospital services to which the measures apply Consider the burden on hospitals Harmonize the measures with other CMS quality programs Weigh the relevance and utility of the measures compared to the burden on hospitals Use measures that are based on currently reported data (i.e., to clinical data registries or all-payer claims databases) or that do not require chart abstraction

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	used many times over the years for measure development and selection		
Committee on Quality Measures for the Healthy People Leading Health Indicators, 2013[44] US	**Setting:** Population health **Intended use:** Healthy People 2020 **Prioritization process:** Not clearly reported **Context:** Have been used to select measures for tobacco use; nutrition, physical activity, and obesity; environmental quality; and maternal, infant, and child health. **Engagement:** No **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied in different contexts	**Eligibility:** N/A **Nature of the measures:** Structure : Funding; School entry laws; Title X, Medicaid family planning waivers,Process : Females receiving reproductive health services,Outcome : Infant deaths; Preterm births **Criteria definition:** Impact (importance) = importance of condition or outcome to be measured Improvability = extent of the gap between current practice and evidence-based best practice and likelihood that the gap can be closed Scientifically sound measure = includes validity and reliability Geographic, temporal, and population coverage = to ensure that measure has sufficient granularity to be useful in monitoring actions to improve health at different geographic levels in important population subgroups Data availability = to ensure that data are readily available in a form useful for quality and performance measurement **Compared to NHQDR:** Both criteria sets include importance, scientific soundness, improvability, applicability to general population, at least some data, and geographic and health systems equity. The Healthy People 2020 criteria set is used to select/prioritize measures for population health, while the NHQDR criteria set is used to select/prioritize measures for quality of care for healthcare. Both frameworks include access and types of care.	Impact (importance) Improvability Scientifically sound measure Geographic, temporal, and population coverage Data availability
Commonwealth Fund, 2004[127] Multiple countries	**Setting:** Healthcare quality of care **Intended use:** The Commonwealth Fund **Prioritization process:** 1. Compile available indicators. All indicators currently available in at least one country (an initial set of more than 1,000 indicators) were considered. 2. Review evidence base, policy relevance, actionability, and interpretability. A list of potential indicators	**Eligibility:** N/A **Nature of the measures:** Structure : Difficulty seeing a specialist; Difficulty getting care nights or weekends; Waiting for emergency care a big problem; Ability to make a same-day doctor's appointment when needed,Process : Breast cancer screening rate,Outcome : Breast cancer 5-year relative survival rate,Patient experience : Composite rating of physician responsiveness as excellent/very good	Feasibility Scientific soundness Interpretability Actionability Importance

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	based on scientific soundness, importance, actionability, and interpretability (approximately 100 indicators) was selected. 3. Assess feasibility for international comparisons. Information on definition, numerator, and denominator specifications, the population represented, periodicity of collection, and data sources for each country were collected. Indicators that had irreconcilable differences in specifications or that were not nationally representative in several countries were discarded (eliminating 50 indicators). 4. Improve international comparability. An iterative process of collecting data in the five countries was applied, the comparability of the specifications was evaluated, and adjustments were made, such as revising coding classifications or age standardization (eliminating an additional five indicators that could not be improved). 5. Ensure reliability. The face validity of preliminary data and investigated any unusual differences to increase the reliability of the indicators were investigated. The final data with experts in each country (final set of 40 indicators) were reviewed. **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Criteria definition:** Feasibility = Only indicators that were already being collected by one or more countries were candidates Scientific soundness = Only indicators that were deemed valid and reliable were considered. Since all of the indicators considered were already in use, determination of scientific soundness relied on existing reviews of the scientific evidence and approval by a consensus process or similar method in one or more countries. Interpretability = Only indicators that allowed a clear conclusion for policymakers were included. This meant that the indicator had to have a clear direction (e.g., higher is either good or bad). Actionability = Only measures of processes or outcomes of care that could be directly affected by health care policy or health care delivery system intervention were eligible. Importance = Only indicators that reflected important health conditions accounting for a major share of the burden of disease, the cost of care, or policymakers' priorities (such as vulnerable populations) were pursued. **Compared to NHQDR:** Both criteria sets include feasibility, scientific soundness, usability, improvability, and importance. The NHQDR criteria set includes numerous other criteria not lists in the Commonwealth Fund criteria set. Both frameworks addresses healthcare delivery, and include the domains effectiveness, access, timeliness, and continuity of care.	

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Connor, 2022[104] Ireland	**Setting:** Quality of care process nursing metrics for acute care **Intended use:** Nursing and Midwifery Project Development Unit Directors, Project Officers, and Work-stream Working Group members **Prioritization process:**The modified Delphi study integrated a four-round survey of 422 nurses, face-to-face meetings with a patient representative and key stakeholders within acute services with a final consensus meeting inclusive of a panel of 26 expert nurse clinicians. **Context:** N/A **Engagement:** Yes 422 nurses, face to face meetings with a patient representative and key stakeholders within acute services with a final consensus meeting inclusive of a panel of 26 expert nurse clinicians **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) Acute care **Validity testing status:** Not tested No indication that the model has been tested empirically	**Eligibility:** Only process measures are eligible. **Nature of the measures:** Process **Criteria definition:** Importance = The data generated by the metric/indicator will likely make an important contribution to improving Nursing or Midwifery care processes Objectivity = The metric/indicator can be measured objectively Process focused = The metric/indicator contributes clearly to the measurement of Nursing or Midwifery care processes (Judgement Framework by Murphy et al., 2019) Operational = Reference standards are developed for each metric or it is feasible to do so; the indicators for the respective metric can be measured (Judgement Framework by Murphy et al., 2019) Feasible = It is feasible to collect and report data for the metric/indicator in the relevant setting (Judgement Framework by Murphy et al., 2019) **Compared to NHQDR:** Both criteria sets include importance, feasibility, and sound measure available. This framework includes objectivity and process focused while the NHQDR criteria set does not. There was insufficient detail for further analysis.	Importance Objectivity Process focused Operational Feasible
Council of Australian Governments, 2011[27] Australia	**Setting:** Australia health system performance and quality **Intended use:** Council of Australian Governments Reform Council **Prioritization process:**The selection criteria for performance indicators draw on principles contained in the Intergovernmental Agreement on Federal Financial Relations, the Aboriginal and Torres Strait Islander Health Performance Framework, and work previously done by Heads of Treasuries, the Productivity Commission and the Council of Australian	**Eligibility:** Where appropriate the indicators should address access to services, quality of service delivery, financial responsibility, patient outcomes and/or patient experience. **Nature of the measures:** Structure : Access to services by type of service compared to need; waiting times for emergency department,Process : Cancer screening rates,Outcome : In hospital mortality rates for acute myocardial infarction, heart failure, stroke, etc.,Patient experience : Measures of the patient experience with hospital services **Criteria definition:** Relevance and appropriateness for policy makers = The performance measure covers an area or subject of key importance in terms of: the	1. Policy Relevance and appropriateness for policy makers Avoidance of perverse incentives Relevance to NHHN agreement and the NHRA 2. Scientific soundness Valid Reliable Attributable Comparable Ability to measure progress over time 3. Efficiency Administratively simple and cost effective

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Government Reform Council. Not all indicators are expected to meet all criteria in all cases, but should be chosen where they are a 'best fit'. The initial set of indicators for the Authority was agreed by COAG in December 2011. However, as an independent statutory authority, the Authority, following extensive clinical and community consultation, will recommend changes to the indicator set that it deems appropriate. Indicators selected for the measurement of safety and quality in healthcare will be developed by the Australian Commission for Safety and Quality in Health Care. Changes to the indicator set must be agreed by Australian health ministers **Context:** N/A **Engagement:** No Model suggested by council **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied to a different context	impact on health outcomes, and/or a significant area of health system policy focus Avoidance of perverse incentives = The measure has been tested for unintended consequences Relevance to National Health and Hospital Network agreement and the National Health Reform Agreement = Performance indicators should be targeted at one or more of the agreed criteria on what should be measured under the reforms; presently relate to: access to services; quality of service delivery; financial responsibility; and patient outcomes and experience Valid = The measure accurately reflects the event or activity it purports to measure; changes in the performance indicator are able to be quantified in a scientifically sound manner Reliable = There are no data gaps; results do not vary because of unrelated factors such as who has performed the data collection; data is able to be collected in the same way from the same sources; there are not significant data delays that compromise the usefulness of the data; data agencies and relevant experts are in agreement that the indicator can be reliably and accurately measured and reported Attributable = The measure reflects outcomes that are substantially attributable to the component of the health system being assessed; a healthcare provider with higher (or lower as appropriate) performance against the indicator would be considered a high performing provider; there is adequate scientific evidence or professional consensus supporting a link between the performance of the indicator and the overall outcome being measured Comparable = The measure readily allows for comparisons: over time (see ability to measure progress over time); at the desired levels of disaggregation (e.g. allows comparisons to be drawn between hospitals, across LHNs, etc.); between target groups (e.g. by Indigenous status); and across the public and private sectors Ability to measure progress over time = Indicator is sensitive enough to provide meaningful information about performance between reporting periods; data will be comparable and remain useful over time, including that baseline data is available; data is collected at intervals that align with the required reporting frequency	

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Administratively simple and cost effective = Assess the costs of data collection, collation and interpretation; consider whether the expected benefits of reporting against the indicators outweigh the administrative burden and costs of data collection; consider whether other measures may offer the same or similar information relating to performance for a lower cost. Utilise existing data sets wherever possible **Compared to NHQDR:** Both criteria sets includes reliability, validity, importance, scientific soundness, data available regularly, and sound measure available. The Council of Australian Governments' criteria set includes "avoidance of perverse incentives" and "administratively simple and cost effective", while the NHQDR does not. Both frameworks address healthcare, and include equity, effectiveness, efficiency, and access.	
Crampton, 2004[45] New Zealand	**Setting:** Primary care performance **Intended use:** N/A **Prioritization process:** Not reported **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Structure : Provider behavior,Process : Diabetes care; prescribing indicators,Outcome : No example reported **Criteria definition:** Reflect important aspects of health status = N/A Be attributable to health care = There must be a link between provider actions and the performance indicator that the provider has some control over Be linked to health outcomes = There must be evidence that improved indicator values are associated with improved health outcomes Be sensitive to change = Performance indicators should detect changes in provider behavior Be sensitive to and discriminate between primary care organizations = N/A Be based on reliable and valid information = Performance indicators should be evidence- based Be precisely defined = N/A Be easily quantifiable = N/A Reflect a variety of dimensions of care = N/A	Reflect important aspects of health status Be attributable to health care Be linked to health outcomes Be sensitive to change Be sensitive to and discriminate between primary care organizations Be based on reliable and valid information Be precisely defined Be easily quantifiable Reflect a variety of dimensions of care Be understood by people who need to act Be relevant to policy and practice Be feasible to collect and report Comply with national processes of data definitions Not be vulnerable to random fluctuation associated with rare events Minimize perverse incentives

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Be understood by people who need to act = N/A	
		Be relevant to policy and practice = N/A	
		Be feasible to collect and report = The cost of collecting data for performance indicators should be within the scope of primary care funding	
		Comply with national processes of data definitions = N/A	
		Not be vulnerable to random fluctuation associated with rare events = Indicators that reflect rare events might be expected to fluctuate from year to year due to statistical instability, as has been clearly demonstrated empirically with respect to hospital admissions. This difficulty may be reduced by using a three year moving average.	
		Minimize perverse incentives = Punitive and constructive uses of indicators effect provider behavior differently	
		Compared to NHQDR: Both criteria sets include reliability, validity, importance, feasibility, usability, and balance across sites. This criteria set includes: Be attributable to health care; Be linked to health outcomes; Be sensitive to change; Be sensitive to and discriminate between primary care organizations; Be easily quantifiable; Be relevant to policy and practice; Comply with national processes of data definitions; Not be vulnerable to random fluctuation associated with rare events; Minimize perverse incentives; and Be precisely defined, while the NHQDR set does not.	
Davis, 2013[46] New Zealand	**Setting:** Hospital performance **Intended use:** N/A **Prioritization process:**Not reported **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied to a different context	**Eligibility:** N/A **Nature of the measures:** Process : Standardized day surgery rate,Outcome : 30-day mortality **Criteria definition:** N/A **Compared to NHQDR:** There are no clear similarities between the two criteria sets. This study's criteria includes: the availability of measures, using administrative data that were well- established in the New Zealand context, but that also had wider support (for example, development and use in the Australian health system). Both frameworks include the domains equity, efficiency, and effectiveness.	Pragmatic considerations of the availability of measures, using administrative data that were well-established in the New Zealand context, but that also had wider support (for example, development and use in the Australian health system).

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Ehreth, 1994[48] US	**Setting:** Hospital quality of care **Intended use:** N/A **Prioritization process:** Not reported **Context:** N/A **Engagement:** No Suggested by author **Evidence-based:** Empirically based **Defined population:** No (target unclear) **Validity testing status:** Tested Applied to a different context	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported **Criteria definition:** Distributional properties should approximate normality = analytic concept (predictive validity, construct validity); measures (mean, standard deviation, skewness, range) Variables should not be redundant = analytic concept (data reduction); measures (pearson correlation coefficient, factor analysis) Values should be reasonably stable across similar hospitals over time = analytic concept (reliability); measure (comparison of means within hospital groups and over time) The measures should reflect the underlying concepts = analytic concept (content validity, construct validity); measures (factor analysis, comparison of known relationships across hospital groups, expert review and consensus) Desired values should not provide perverse incentives to hospitals = measure (comparison with known effects of achieving desired variable values on hospital behavior) Values should not arbitrarily be in the control of either the government or the industry = measure (comparison with known effects of policy and hospital actions in variable values) **Compared to NHQDR:** Both criteria sets include validity and reliability. This study's criteria include: Distributional properties should approximate normality; Variables should not be redundant; Values should be reasonably stable across similar hospitals over time; The measures should reflect the underlying concepts; Desired values should not provide perverse incentives to hospitals; Values should not arbitrarily be in the control of either the government or the industry, while the NHQDR does not.	Distributional properties should approximate normality Variables should not be redundant Values should be reasonably stable across similar hospitals over time The measures should reflect the underlying concepts Desired values should not provide perverse incentives to hospitals Values should not arbitrarily be in the control of either the government or the industry
Etches, 2006[49] Canada	**Setting:** Population health indicators **Intended use:** N/A **Prioritization process:** Comprehensive literature review of historical development of population health indicators **Context:** N/A	**Eligibility:** N/A **Nature of the measures:** Outcome : Population health indicators, Unclear : Not reported **Criteria definition:** N/A **Compared to NHQDR:**	Built on consensus Based on a conceptual framework Valid Sensitive Specific Feasible Reliable and sustainable Understandable

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Engagement: No Suggested by authors **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) Population health indicators **Validity testing status:** Not tested No indication that this has been tested empirically	Both criteria sets include validity, reliability, feasibility, and usability. This criteria set includes: built on consensus; based on a conceptual framework; sensitive; specific; timely; comparable; flexible for use at different organizational levels; include measures of all these aspects: incidence and prevalence, central tendency (e.g., mean, median, etc.) and distribution, stratification by subpopulations, while the NHQDR set does not.	Timely Comparable Flexible for use at different organizational levels Include measures of all these aspects: incidence and prevalence, central tendency (e.g., mean, median, etc.) and distribution, stratification by subpopulations
Evans, 2009[50] Australia	**Setting:** Healthcare quality of care **Intended use:** N/A **Prioritization process:** Identify the problem, Identify the perspective from which to measure, Focus on transitions through the health system, Identify the indicator, Prioritize indicator selection and action, Test the indicator **Context:** N/A **Engagement:** No **Evidence-based:** No **Defined population:** Yes (framework target described in detail) Healthcare broadly **Validity testing status:** Not tested	**Eligibility:** N/A **Nature of the measures:** Structure : A preoperative checklist exists that requires staff to document whether VTE prophylaxis has been considered,Process : Incidence of potentially preventable, hospital-acquired VTE,Outcome : Percentage of admitted adult patients assessed for risk of VTE **Criteria definition:** Important and relevant = Has face validity; Assesses an important leverage point for improving quality; Fosters real-quality improvement and has the potential to affect health; Demonstrated improvement or opportunity for improvement exists; Considerable variation in quality of care exists; Aspect of quality is under provider or health system control; Significant to target audiences; important, relevant and acceptable to stakeholders; Should not create incentives or rewards to improve without truly improving quality of care Scientifically acceptable = Valid, measures the intended aspect of quality, accurately represents the concept being evaluated; Relationship to quality is based on scientific evidence; Well defined and precisely specified; Sufficient variation can be explained by provider performance after patients' characteristics are taken into account; Data sources are comparable, variation in measurement is small; Reliable, producing the same results a high proportion of time in the same population; Reasonable sample size exists to detect actual differences; Captures all possible cases and bias related to case exclusion or limited data are minimal; Has been validated rigorously; Data shown to be of adequate quality to allow meaningful statistical analysis; Risk adjustment is adequate to address confounding bias and to differentiate between providers; Statistical testing can be applied to explain that the difference in performance level is greater than would be expected by chance	Important and relevant Scientifically acceptable Usable Feasible

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Usable; Intervention is possible when improvement is needed; Effective (understandable and clear) presentation and dissemination strategies exist; Measurement will not encourage undesired behaviour; Has been used effectively in the past and/or has high potential for working well with other indicators currently in use; Useful for stakeholder decision-making; Universal – suitable for a broad range of organizations, healthcare systems, populations and clinical disciplines Feasible = Feasible to calculate, benefits exceed financial and administrative burden of implementation; Data should be collected for routine clinical or organizational reasons or be available quickly with the minimum of extra effort and cost; Required data available across the system; Consistent construction and assessment of the measure; Confidentiality concerns are addressed; Audit strategy can be implemented; Quality of data is known; Capacity of data and measure to support subgroup analyses; Existence of prototypes **Compared to NHQDR:** Both sets include Reliability, Validity, Importance, Scientific soundness, Feasibi lity, Usability, Applicability to general population, Data available regularly, Linkable to established indicator sets, Balance across health conditions, Balance across sites of care, At least some state data, and Improvability. The main categories in this study's are Important and Relevant, Scientifically acceptable, Usable, and Feasible, and all other criteria are subcriterias for these categories, while there are no subcriteria for the NHQDR set.	
Fisher, 2013[52] US	**Setting:** Mental health care quality of care **Intended use:** N/A **Prioritization process:**Representatives from each of the participating countries were contacted to identify peer-reviewed journal articles, government reports, white papers and other 'gray literature' on population-based quality or performance measurement initiatives in mental health being developed or implemented in each country at the national or other representative level (e.g. province and state, etc.). Initiatives were extracted into a standard document listing context, mental health indica- tors and original	**Eligibility:** Indicators must be mental health and/or substance use quality indicators. **Nature of the measures:** Structure : Access to primary care, emergency mental health care,Process : Preventive medical care or screening,Outcome : Blood/urine monitoring outcomes **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include applicability to national priorities. The criteria for the mental health quality indicators includes "the initiative must describe indicators related to mental health and/or substance use" and "the indicators should (i) be precisely defined at the numerator and denominator level, (ii) contain infor- mation about data sources and (iii) measure quality (as defined by the six US Institute of Medicine domains of effectiveness, efficiency, equitability, safety,	Related to mental health and/or substance use Precisely defined at the numerator and denominator level, contain information about data sources, and measure quality (as defined by the six US Institute of Medicine domains of effectiveness, efficiency, equitability, safety, timeliness and patient and/or community centered) National- or regional- level focus, or otherwise be used to assess the performance among organizations or providers

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	domains, process of indicator development, intended or actual use and related studies and reports. In a second step, performance measures, performance indicators and outcome measures that met the three main criteria were collated into a single document and determined for inclusion in the current review. The measures were then organized and assigned to a list of 16 domains and 77 sub- domains initially developed for an international survey. Researchers at Columbia University reviewed the list of indicators and identified indicators that were unclear or were classified differently to develop consen- sus on the classification. Discrepancies were resolved by dis- cussion among the three lead authors to develop consensus on the evaluation and to iteratively modify the framework of domains and subdomains to better reflect the range and purpose of the measures collected. Coding was continued until 100% consensus was achieved. **Context:** N/A **Engagement:** Yes Representatives from each country submitted reports of quality measurement initiatives in mental health. Researchers at Columbia University reviewed the list of indicators and identified indicators that were unclear or were classified differently to devel **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) Mental health care **Validity testing status:** Not tested No indication that this criteria set has been empirically tested	timeli- ness and patient and/or community centered)", while the NHQDR criteria does not. Both frameworks include safety, access, efficiency, types of care, care coordination, and continuity of care.	

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Flowers, 2005[53] UK	**Setting:** Public health **Intended use:** N/A **Prioritization process:**Declarative title? Description (with definitions where appropriate)? From which organisation/unit does this indicator origi- nate? What is the broad policy area to which you would allocate this indicator to? Rationale with evidence? What is this indicator purporting to indicate (e.g. HbA1C- control; Retinopathy-control/quality of service)? Face validity? Construct validity? Data Numerator (N) and denominator (D) and comparator (each has a source, or means of data collection and quality assurance (provenance))? Routine or special collection? What is the unit of analysis? What level (place, institution, person.) is being analysed? Time? (frequency) Qualitative/quantitative? Disease classification (be specific about type of diabetes)? If calculated—which method? Miscellaneous Strengths? Weaknesses? Risk of gaming and perverse incentives? How is this likely to influence (improve) practice/ behaviour?	**Eligibility:** N/A **Nature of the measures:** Unclear : Not clearly reported **Criteria definition:** Relevance = clear rationale for developing an indicator, which includes a link to current policy; should be timely, and there should be evidence that the indicator is a plausible proxy for the underlying measure of interest Validity = have face validity in that it should be likely to measure what it purports to measure; should have construct validity - many indicators are complex composite measures combining several elements into a single figure, elements should be plausible and the composition of the indicator should make sense Behavior = indicators should be 'well-behavior', that is, a change in the value of the indicator should be interpretable, and, for composite indicators, the indicator value should change in an appropriate direction if the underlying elements change Clear specification = clear and comprehensive information should be available about the construction of an indicator, including details of numerator and denominator data and the calculations necessary to derive the indicator value Repeatability = it's important to consider changes in the components of the indicator, including changes in collection or coding of the data underlying indicators; if a change is significant, it may be necessary to revise the indicator Construction and deconstruction = for complex measures, e.g., life expectancy, it is valuable to be able to deconstruct the measure into its components, e.g., cause-specific or age-specific death rates Feasibility = indicators should usually be constructed using routinely collected data; it is important to consider the availability and quality of both numerator and denominator data; calculations should be transparent; ideally, given the appropriate data it should be possible to reconstruct an indicator and derive the same values **Compared to NHQDR:** Both criteria sets include reliability, validity, importance, feasibility, and usability. This criteria set includes: behavior; construction and deconstruction, while the NHQDR criteria set does not.	Relevance Validity Behavior Clear specification Repeatability Construction and deconstruction Feasibility

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Is the indicator mainly associated with structure, process or outcome? **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** Empirically based **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication that this has been tested empirically		
Haj-Ali, 2017[55] Canada	**Setting:** Primary care performance **Intended use:** Ontario PCPM Summit (co-sponsored by Health Quality Ontario, Canadian Institute for Health Information, MOHLTC, Cancer Care Ontario, Institute for Clinical Evaluative Sciences, eHealth Ontario and Local Health Integration Networks) **Prioritization process:**Environmental scan to examine current state of Primary Care Performance Measurement in Ontario, across Canada and internationally (comprehensive literature review, grey literature, contacts with organizations through Ontario and Canada that HQO know were doing relevant research or developing performance measurement frameworks for primary care. Steering Committee for the Summit established criteria (described in prioritization criteria field) to shortlist a set of measurement priorities for the Summit participants to consider. Prepared and distributed worksheet of 60 potential measurement priorities and other background material before meeting. 61 senior leaders attended Summit; following discussion, they voted for highest performance measurement priorities. Steering Committee identify set of measurement priorities for the PCPM	**Eligibility:** N/A **Nature of the measures:** Process : mention of inclusion but no example,Outcome : mention of inclusion but no example,Patient experience : mention of inclusion but no example,Unclear : Stated that the focus was on process, outcome, and patient experience, and not on structure, but no 100% clear on specific type of measures **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include applicability to the general population, balance across sites, improvability, and value. The criteria set in this study includes "The aspect of primary care performance is linked in evidence to one or more components of the IHI's Triple Aim: Reducing/controlling the per-capita cost of healthcare (better value), Improving the patient experience of care (better care)", while the NHQDR does not. Both frameworks include equity as a cross-cutting dimension, and the components safety, effectiveness, efficiency, timeliness, access, patient/family centeredness, types of care, care coordination, continuity of care, and health systems infrastructure cap	1. The information is valuable to have on a regular basis for one or more purposes (e.g., service planning, management or quality improvement) at the practice and/or system (community, regional or provincial) levels. 2. There is a potential for comparisons of performance across practices, organizations, communities, regions, provinces/territories and/or countries. 3. The aspect of primary care performance is linked in evidence to one or more components of the IHI's Triple Aim: Improving the patient experience of care (better care). Improving population health (better health). Reducing/controlling the per-capita cost of healthcare (better value).

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	framework based on Summit and survey results. Measures Working Group selected preferred measures for each measurement priority building on and guided by the criteria that were used during the Summit. Technical Working Group advised on technical specifications and infrastructure requirements for data extraction, analysis and reporting. **Context:** N/A **Engagement:** Yes Summit of primary care stakeholders, stakeholder survey helped identify system- and practice-level measurement priorities and related specific performance measures **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication this has been tested empirically		
Ham, 2015[58] NHS Group Department of Health, 2014[103] UK	**Setting:** UK local health systems performance **Intended use:** Department of Health in UK **Prioritization process:**Consultation with key stakeholders; draw on current and historical policy and practice in the UK and internationally, and the published literature; conducted broad preliminary trawl of more than 1,500 indicators from currently available sources that could be used to report on performance; narrowed down to an illustrative list of about 200 indicators relevant from a CCG perspective; mapped the set of indicators onto the population groups and domains of performance proposed in terms of reference. **Context:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure : Sickness absence - percentage of employees who had at least one day off in the previous week; maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP; GP of choice,Process : Antenatal assessments within 13 weeks; people with diabetes who have received nine care processes,Outcome : Infant mortality,Patient experience : Patient experience of GP services **Criteria definition:** Relevance and significance = Used origins of an indicator as a rough marker; for example, if an indicator is shared between two or all three Outcomes Frameworks, or appears in the COIS and NHS England's Delivery Dashboard used for CCG assurance, then it was deemed relevant for consideration; also considered some indicators published by Public Health England for local authorities as relevant at the CCG level **Compared to NHQDR:**	Importance: Relevance and significance

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Engagement: Yes Consultation with technical experts and stakeholders on emerging findings in workshops, including from members of clinical commissioning groups, professional societies, national bodies and patient groups; Health Foundation was asked to review indicators o **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	Both criteria sets include importance/relevance and significance. The NHQDR has many other criteria not listed in the set by the King's Fund. Both frameworks address health system delivery in some way, and include access, safety, effectiveness (health outcomes in the framework in this report), and types of care.	
Hatef, 2018[59] US	**Setting:** Population health measurement **Intended use:** N/A **Prioritization process:** The authors searched peer-reviewed, expert-authored literature and current public health measures. Using a semi-structured analysis, a framework was proposed, which consisted of a conceptual model of several domains and identified population health measures addressing them. Stake-holders were convened to review the framework and identified the most feasible population health measures considering the underlying health information technology (IT) infrastructure in Maryland. **Context:** N/A **Engagement:** Yes Stake-holders were convened to review the framework and identified the most feasible population health measures considering the underlying health information technology (IT) infrastructure in Maryland. **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail)	**Eligibility:** N/A **Nature of the measures:** Process : BMI screening and follow-up for community/population,Outcome : Age-adjusted mortality rate from heart disease for population **Criteria definition:** Population/community focused = Relevant to community level interventions (eg, for entire state, county, or special target population across region); Health System Interventions (eg, a hospital system, ACO, or provider consortia); Bringing population issues into clinical services (eg, PCP or care manager/outreach nurse) Importance/applicability = Population-based performance measures; Population-level factors that are important to take into account for clinical/public health intervention Development of a balanced score card of population health = Measures not related to medical care (ie, more social); Focusing on population facets of medical care (ie, the full denominator of those in need, not just those receiving care); Focusing on interplay between public health interventions and medical care; A type of structure-oriented QI measure that will serve as a motivator to help build new infrastructure for data collection for population health (eg, a metric assessing the collection of SES data in EHRs); Tools that will support not just the current state programs, but also future innovations (eg, as described in the SIM grant); Relevant to small areas (ie, when defining communities, one can go beyond just county or large zip code); Range of temporality (ie, some measures address short-term	Population/community focused Importance/applicability Development of a balanced score card of population health Overall practicality and strategic value Data feasibility/supports and expands digital infrastructure Scientific evidence/measures attributes

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Validity testing status: Not tested No indication that this has been tested empirically	outcomes, others longer term; some of the outcomes will require being in it for the long haul)

Overall practicality and strategic value = Measurement areas not previously addressed by HSCRC/MDH or measures already identified, but where further work is needed; Could be accomplished with limited resources (ie, not a new major community survey); Fills a gap on the comprehensive framework developed

Data feasibility/supports and expands digital infrastructure = Data are currently available digitally or could be available in next 3 years; Capitalizes and expands on new data assets (eg, EHR, CRISP)

Scientific evidence/measures attributes = Some evidence that measures matter for health and welfare; Ideally some preliminary measurement work exists; Some previous validation of accuracy/feasibility desirable; Some previous measure standards/certification desirable

Compared to NHQDR:
Both criteria sets include importance, scientific soundness, and feasibility. This study's criteria also includes: population/community focused; development of a balanced score card of population health; overall practicality and strategic value, while the NHQDR set does not. | |
| Hearns haw, 2001[60] UK | **Setting:** Healthcare quality of care
Intended use: N/A
Prioritization process: RAND/UCLA appropriateness method
Context: N/A
Engagement: Yes 26 academic experts and 23 practitioner experts
Evidence-based: No
Defined population: Yes (framework target described in detail) Healthcare broadly
Validity testing status: Not tested | **Eligibility:** N/A
Nature of the measures: Unclear
Criteria definition:
N/A

Compared to NHQDR:
There were some similar criteria such as Reliability, Validity, Importance, Scientific soundness, Feasibility, Usability, Improvability, Data available regularly, Balance across treatment sites, Linkable to established indicator sets, and Sound measure available. The criteria in this study were not categorized into a key term like the current NHQDR criteria are. Many criteria in this study such as "criteria are described in unambiguous terms" are not in the current NHQDR criteria. | Described in unambiguous terms
Based on a systematic review of research evidence
Validity of identified research is rigorously appraised
Include clear definitions of the variables to be measured
Explicitly state the patient populations to which they apply
Capable of differentiating between appropriate and inappropriate care
Linked to improving health outcomes for the care being reviewed
Explicitly state the clinical settings to which they apply
Collection of information required for criteria based review minimizes demands on staff |

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
			Method of selecting criteria is described in enough detail to be repeated Accompanied by clear instructions for their use in reviewing care Systematic review used to guide the selection of criteria is up to date Pilot tested for practical feasibility Include aspects of care that are relevant to patients Collection of information for criteria based review is acceptable to those patients whose care is being reviewed Bibliographic sources used to identify research evidence are specified Decisions on trade-offs between outcomes from different treatment options are stated Collection of information required for criteria based review minimizes demands on patients Method of synthesizing evidence and expert opinion is made explicit Prioritised according to the quality of supporting evidence Prioritised according to their impact on health outcomes Criteria used to assess the validity of research are stated Similar criteria should emerge if other groups review the same evidence Collection of information for criteria based review is acceptable to those staff whose care is being reviewed Expert opinion is included in the process of developing review criteria Criteria used in previous quality reviews of the same clinical topic are considered for inclusion
Hurtado, 2001[62] US	**Setting:** U.S. healthcare **Intended use:** NHQDR **Prioritization process:**N/A	**Eligibility:** N/A **Nature of the measures:** Unclear	1. Importance of what is being measured • Impact on health. What is the impact on health associated with this problem?

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Context: NHQDR **Engagement:** Unclear Not reported **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that the model has been tested empirically	**Criteria definition:** Importance = refers to whether the area under consideration should be measured at all or whether it is important in a clinical care sense, important to the general population, or important to improve the quality of health care delivery. The subject of measurement can refer to a health condition or to an organizational aspect of the health care system that influences quality of care Scientific soundness = refers to properties of the measure that often have to be assessed formally by researchers; they largely determine the credibility of the measure, particularly among health care practitioners Feasibility: refers to the feasibility of implementing the selected measures: that is, once it has been decided what to measure and how to measure it, one must examine whether it can actually be measured **Compared to NHQDR:** same criteria (developed for NHQDR) Both frameworks addresses health care, and include the components safety, effectiveness, patient-centeredness, and timeliness.	• Meaningfulness. Are policy makers and consumers concerned about this area? • Susceptibility to being influenced by the health care system. Can the health care system meaningfully address this aspect or problem? 2. Scientific soundness of the measure • Validity. Does the measure actually measure what it is intended to measure? • Reliability. Does the measure provide stable results across various populations and circumstances? • Explicitness of the evidence base. Is there scientific evidence available to support the measure? 3. Feasibility of using the measure • Existence of prototypes. Is the measure in use? • Availability of required data across the system. Can information needed for the measure be collected in the scale and time frame required? • Cost or burden of measurement. How much will it cost to collect the data needed for the measure? • Capacity of data and measure to support subgroup analyses. Can the measure be used to compare different groups of the population?
Institute of Medicine, 2005[63] US	**Setting:** Health care quality of care **Intended use:** Institute of Medicine **Prioritization process:** Not clearly reported, but review of existing processes informed the process used and measures developed by the team. **Context:** N/A **Engagement:** No Suggested by authors and team	**Eligibility:** N/A **Nature of the measures:** Structure : Access/availability of care,Process : Cancer screening,Outcome : Mortality,Patient experience : Satisfaction with experience of care **Criteria definition:** Scientifically sound = this criterion concerns reliability, validity, and explicitness of the evidence base Reliability = measure consistently produces the same result when repeated within the same population and setting	Scientifically sound Feasibility Importance Alignment Comprehensiveness

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Evidence-based: No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	Validity = addresses the question of whether a measures reflects what it is intended to measure Evidence base from which a measure is derived must be explicitly = for example, randomized controlled trials, case control studies, observational studies, formal consensus processes Feasibility = data needed for a measure must be in current use, across the system, and examined for the cost or burden of measurement on providers Importance = health problem addressed by a measure should be a leading cause of death or disability or associated with high resource use; a measure must have an impact on health, be tied to national goals, and be susceptible to being influenced by the health care delivery system; ideally, a measure should be stratified by race, gender, and age Alignment = optimally, measures should be selected from existing leading measure sets that are calculated with the same technical specifications for both the numerator and denominator to reduce redundancy and the burden of reporting Comprehensiveness = measures selected should be part of a set to reflect quality in a particular area of core or bundled services of necessary care for a given condition; each measure in the set should meet the criterion of importance to warrant inclusion; to demonstrate comprehensiveness, the set of measures must address the way the care is delivered and the nature of the quality problem involved-- underuse, misuse, or overuse **Compared to NHQDR:** Both criteria sets include scientifically sound, validity, reliability, feasibility, importance, applicability to national priorities, and linkable to established indicator sets. The IOM criteria set also includes: Be susceptible to being influenced by the health care delivery system; Ideally, a measure should be stratified by race, gender, and age; Measures selected should be part of a set to reflect quality in a particular area of care or bundled services of necessary care for a given condition; The set of measures must address the way the care is delivered and the nature of the quality problem involved--underuse, misuse, or overuse, while the NHQDR does not. Both frameworks address health system delivery or performance, and include equity, access, effectiveness, efficiency, timeliness, patient-	

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		/family-centeredness, types of care, care coordination, continuity of care, and health systems infrastructure capabil	
Institut e of Medici ne, 2010[19] US	**Setting:** U.S. healthcare system **Intended use:** To document national trends, identify gaps in care, and paint a picture of the state of health care quality and disparities **Prioritization process:**N/A **Context:** NHQDR **Engagement:** No Model suggested by authors **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this model has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Unclear **Criteria definition:** Recommendations Importance = an area likely to be high-impact based on potential population impact, high cost, variation in quality, performance, or existing disparities Improvability = evidence (not limited to RCTs) that improvement can be made Sound measure available = scientifically sound measures have been developed to assess this area Applicability to national priorities = measure progress in at least one of the national prioritiy areas for improving the quality of health care and eliminating disparities Value = measure has the potential to increase health care value by narrowing a defined quality gap (health outcome for resource investment; degree of clinical preventable burden) Population equity = measure documents significant inequities in care by race, ethnicity, language need, or socioeconomic status Geographic and health systems equity = measure documents geographic or health system variation in performance Data availability = appropriate national data source exist that would support assessment of performance overall as well as among disparity populations **Compared to NHQDR:** Same criteria (the criteria were designed for the NHQDR) The framework is the same.	Assumed criteria used to 2010: Primary Criteria 1. Importance • impact on health (e.g., clinical significance, prevalence); • meaningfulness; and • susceptibility to being influenced by the health system (e.g., high utility for directing public policy, and sensitive to change). 2. Scientific Soundness (assumed because AHRQ only uses consensus-based endorsed measures). 3. Feasibility • capacity of data and measure for subgroup analysis (e.g., the ability to track multiple groups and at multiple levels so a number of comparisons are possible); • cost or burden of measurement; • availability of required data for national and subgroup analysis; and • measure prototype in use. 4. Usability: easy to interpret and understand (methodological simplicity). 5. Type of Measure: evidence-based health care process measures favored over health outcome measures because most outcome measures were too distal to an identified intervention. Secondary Criteria • applicable to general population rather than unique to select population; • data available regularly/data available recently; • linkable to established indicator sets (i.e., Healthy People 2010 targets); and • data source supports multivariate modeling (e.g.,

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
			socioeconomic status, race, and ethnicity).
			Balancing Principles
			• balance across health conditions;
			• balance across sites of care;
			• at least some state data; and
			• at least some multivariate models.
			Committee recommendation
			Measures identified in environmental scan for importance
			• Criterion A: improvability (evidence that improvement can be made),
			• Criterion B: sound measure available (scientifically sound measures have been developed to assess this area),
			• Criterion C: applicability to national priorities (measures progress in at least one of the national priority areas for improving the quality of health care and eliminating disparities).
			• Plus:
			o Criterion D: value (measure has the potential to increase health care value by narrowing a defined quality gap, e.g., health outcome for resource investment; degree of clinically preventable burden),
			o or Criterion E: population equity (measure documents significant inequities in care by race, ethnicity, language need, or socioeconomic status),
			o or Criterion F: geographic and health systems equity (measure documents geographic or health system variation in performance).
			Additional recommendation

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
			• Quantified population impact or value of efforts to improve quality and to reduce disparities
Irish Department of Health, 2013[64] Ireland	**Setting:** Ireland healthcare quality of care **Intended use:** Not clear but potentially Ireland Minister for Health **Prioritization process:**Scoping analysis of literature and existing indicators and process, calculation of indicators using data from the Hospital Inpatient Enquiry System **Context:** N/A **Engagement:** Unclear Noted that next phase will engage stakeholders in establishing the reporting mechanism for National Healthcare System Performance Quality Indicators. Indicators assessed as feasible in the report will be further developed and evaluated in consulation with **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Structure : No example, but mentioned to be included in report,Process : No example, but mentioned to be included in report,Outcome : In-hospital mortality within 30 days after acute myocardial infarction **Criteria definition:** Feasibility = Are there agreed international definitions and guidelines for the indicator? Is there potential for international comparability? Are all of the necessary variables currently coded in Hospital Inpatient Enquiry? Are there sufficient numbers of cases (both numerator and denominator) with identified conditions to support the calculation of rates? Are there ICD-10-AM codes available for the conditions assessed? Are there sources apart from Hospital Inpatient Enquiry available that are more accessible and robust? Are the indicators representative of a range of process, structure and outcome indicators? **Compared to NHQDR:** Both criteria sets include feasibility. The criteria in this study were focused specifically on feasibility, while the NHQDR includes a list of numerous other criteria.	Feasibility
Jencks, 2000[65] US	**Setting:** Medical care delivered to medicare beneficiaries **Intended use:** Medicare **Prioritization process:**Using the 5 criteria noted below, authors adopted or developed 24 process-of-care measures. Each measure was based on professionally developed, widely accepted practice guidelines that were translated into measures either as part of a larger partnership (Health Plan Employer Data Information Set and Diabetes Quality Improvement Project) or national public	**Eligibility:** Relate to primary prevention, secondary prevention, or treatment of acute myocardial infarction, breast cancer, diabetes mellitus, heart failure, pneumonia, and stroke **Nature of the measures:** Process : Administration of aspirin within 24 hr of admission,Outcome : Patient (screened for) or given pneumococcal vaccine **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance, scientific soundness, feasibility, and improvability. This criteria set included "there is at least anecdotal evidence that peer review organizations can intervene	The disease is prevalent and a major source of morbidity or mortality in the Medicare population There is strong scientific evidence and practitioner consensus that there are processes of care that can substantially improve outcomes Reliably measuring the delivery of these processes of care is feasible There is a substantial "performance gap" between current performance and desirable performance There is at least anecdotal evidence that peer review organizations can intervene

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	health surveillance effort (Behavioral Risk Factor Surveillance System) or by Health Care Financing Administration staff in consultation with experts and relevant professional groups. **Context:** N/A **Engagement:** Yes Some measures were by Health Care Financing Administration staff in consultation with experts and relevant professional groups **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	effectively to improve performance on the measures" while the NHQDR set does not.	effectively to improve performance on the measures
Katz, 2004[108] Canada	**Setting:** Family practice quality of care **Intended use:** N/A **Prioritization process:**First, a review of the literature identified previously used indicators of quality in family practice. These indicators were then sorted into those potentially measurable with the administrative data available at Manitoba Centre for Health Policy, and those which required other sources of data. The latter group was excluded from the study. A refined list of potential indicators was then presented to three groups of family physicians in a series of focus groups. This process provided the opportunity for input from practising physicians to ensure that each indicator chosen was relevant and acceptable. The intent was to facilitate an interactive process to arrive at a final list of acceptable indicators. Minor changes to some definitions were made during the initial analyses when it became clear that the original definitions were not sensitive enough.	**Eligibility:** N/A **Nature of the measures:** Process : Childhood immunization; cervical cancer screening; anticoagulant medication management **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include data available and validity. The difference is that these are the only two criteria for this set, while the NHQDR has additional criteria.	First, the data necessary to measure each indicator needed to be readily accessible in the routinely generated administrative data available to Manitoba Centre for Health Policy. Second, practising, community-based family physicians needed to accept the validity of each indicator as an acceptable measure of quality of care relevant to their own practice.

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Context: N/A **Engagement:** Yes A refined list of potential indicators was then presented to three groups of family physi- cians in a series of focus groups. This process provided the opportunity for input from practising physicians to ensure that each indicator chosen was relevant and **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically		
Kazan djian, 1995[66] Thoms on, 1997[15] 1 US	**Setting:** Maryland hospital performance **Intended use:** N/A **Prioritization process:** Not reported **Context:** The criteria was based on The Quality Indicator Project (that involved US, Japan, and England). **Engagement:** No Suggested by authors **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Process : Unscheduled returns to a Special Care Unit,Unclear : Ceserean section and inpatient mortality were listed as process of care indicators, but they are typically structure or outcome indicators. It's also unclear whether authors referred to these as examples of the larger Quality Indicator Project, or the one in the study (Maryland Hospital Association QI Project) **Criteria definition:** Measurement of quality = By focusing on the user as the operator of the indicators, the QI Project has developed a highly effective process of education. Ongoing cooperation in research efforts with its participating hospitals and active involvement of Project staff in the interpretation of patterns, trends, and profiles enhances the investigative efficacy of the Project. Realization that indicators often may reflect the completeness, accuracy, specificity of the data and not the goodness of the care. Indicator reliability and validity = Validity of a tool is determined through its ability to measure/quantify what it was created to measure; Reliability describes the tool's ability to measure and quantify in a predictable manner, with the least amount of error Usefulness of institutional trends, patterns, and profile = How useful are institution-specific indicator rates? Could these rates readily translate into trends and profiles that would help identify real	Measurement of quality Indicator reliability and validity Usefulness of institutional trends, patterns, and profiles

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		differences in performance among hospitals? How does one investigate these questions? **Compared to NHQDR:** Both criteria sets include validity, reliability usability, and data available regularly. The Maryland Hospital Association Quality Indicator Project includes: Measurement of quality - "indicators of performance do not measure quality, people do" and "indicators of performance may be measuring the quality of the data and not the goodness of care", while the NHQDR does not.	
Kmetik, 2007[68] US	**Setting:** Physician performance **Intended use:** PCPI **Prioritization process:**Expert panel selection; Conduct literature search/evidence; identify desired outcomes and measurement; work groups draft measures: identify appropriate patient population, specify numerator, specify denominator, define any relevant exclusions (exceptions), specify data elements, consider risk adjustment needs, develop specifications for multiple data sources (administrative data, electronic systems, etc.), specify frequency of measurement, indicate appropriate use of each measure; PCPI membership and public comment periods; PCPI Work Groups consider revisions to measures based on comments, and review technical specifications including CPT Category II codes (if required); Review by PCPI membership; If Approved by PCPI, then Testing of measures (e.g., CMS pilot projects, physician practice volunteers); If Revision is needed, then continue to revise until revision is not needed; When Revision is not needed, then Public release of measures for adoption and implementation; Maintain/Update	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance and scientific soundness. The PCPI criteria set includes: The topic is a gap area or an area with high variation in care; The topic is likely to generate measures in the following four areas (termed "high value"): care coordination, patient safety, appropriateness/overuse, and quality improvement collaboratives, while the NHQDR does not.	1. The topic area is an area designated as high impact (by the IOM, NPP, etc.) 2. The topic is a gap area or an area with high variation in care 3. The topic has an adequate evidence base If the above three criteria are met, PCPI evaluates whether the topic under consideration is likely to generate measures in the following four areas, which it terms "high value": care coordination, patient safety, appropriateness/overuse, and quality improvement collaboratives

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	measures (minimum every 3 years, or as necessary) If Not Approved by PCPI, then NQF Review, Potential Endorsement **Context:** It has been used by PCPI to develop measures. **Engagement:** Yes Consortium is staffed by the AMA and led by a 23-member Executive Board, and is composed of more than 100 national and state medical societies, experts in methodology, an data collection, AHRQ, and CMS. After a topic has been approved, an topic-specific e **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Criteria has been used by PCPI, and the resulting developed measures have been heavily used by CMS's Physician Quality Reporting Initiative. In addition, uses of the developed measures include integration into electronic health records, Maintenance of Cer		
Kramers, 2003[69] Multiple countries	**Setting:** European community health **Intended use:** European Union Health Monitoring Programme **Prioritization process:**Experts participated from all EU Member States, Norway and Hungary. The team has met five times between 1999 and October 2000. Draft texts were prepared by the project coordinator and were subject of substantial amendment and detailed discussion during these meetings. Also between meetings, there was much bilateral communication. In the early stages the discussion was focused on the basic frame of the indicator list, the criteria and the concept of user-windows. During	**Eligibility:** N/A **Nature of the measures:** Structure : Structure/financing of the national health system; insurance coverage,Process : Waiting lists/times; variations in specific surgeries/interventions,Outcome : Mortality, wound infection,Patient experience : Perception of the health systems; complaints **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include reliability, validity, scientific soundness, data available regularly, linkable to established indicator sets, improvability, and applicability to national priorities. The ECHI criteria set includes "be comprehensive", "the probability of changing policy interests calls for a high degree of flexibility, made possible by current electronic database systems", while the NHQDR does not.	1. Be comprehensive, i.e. the multi-purpose nature of the monitoring objectives require the coverage of all domains which are normally included in the public health field; in addition, the indicator set should be coherent in the sense of conceptual consistency. 2. Take account of earlier work in the area of indicator selection and definition, especially that by WHO-Europe, OECD, and the Commission Services in Eurostat; thus avoiding duplication of effort and promoting cooperation between international organizations 3. Cover the areas in the public health field which Member States want to

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	the second year, it shifted towards the selection and definition of the indicators. Many indicator proposals were taken from existing lists of WHO-Euro and OECD, when there seemed no reason to deviate from these. The Member State policy profiles were used to also include new proposals for which no regular data collection is still available. In a final stage, the list was integrally checked with Eurostat to ensure a sufficiently realistic approach. During the second half of the project period and thereafter, the ECHI results were discussed intensely in the HMP project coordinators meetings, and they increasingly served as a frame of reference for work in other projects. The final results were presented in the Eurostat meeting on public health statistics, and were taken up as a preliminary guideline for further developments in European health statistics. **Context:** N/A **Engagement:** Yes To develop a set of health indicators for the ECHI project **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that the model has been tested empirically	Both frameworks include health care/systems resources/infrastructure capabilities.	pursue (MS policy priorities; also regions within MS may have their own health policies); in addition, it should meet the needs of Community policies (Community policy priorities). 4. A specific public health area should be guided by scientific principles. 5. Indicators (and underlying data) should meet a number of methodological and quality criteria concerning e.g., validity, timeliness, sensitivity, and comparability etc. 6. The probability of changing policy interests calls for a high degree of flexibility, made possible by current electronic database systems. 7. Selection of indicators should be based, to start with, on existing and comparable data sets for which regular monitoring is feasible, but should also indicate data needs and development areas.
Kringos, 2010[70] Multiple countries	**Setting:** European primary care quality of care **Intended use:** N/A **Prioritization process:** A systematic review of the primary care literature published between 2003 and July 2008 was carried out. This resulted in an overview of: (1) the dimensions of primary	**Eligibility:** N/A **Nature of the measures:** Structure,Process,Outcome **Criteria definition:** Relevance = covering an essential aspect of a dimension Precision = precise formulation assuring easy-to-fill data (preferably numerical)	Relevance Precision Flexibility Discriminating power

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	care and their relevance to outcomes at (primary) health system level; (2) essential features per dimension; (3) applied indicators to measure the features of primary care dimensions. The indicators were evaluated by the project team against criteria of relevance, precision, flexibility, and discriminating power. The resulting indicator set was evaluated on its suitability for Europe-wide comparison of primary care systems by a panel of primary care experts from various European countries (representing a variety of primary care systems). **Context:** N/A **Engagement:** No Model suggested by authors **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) Users of primary care health system **Validity testing status:** Tested Applied in different context	Flexibility = likely to fit in various health systems in Europe Discriminating power = yielding a range and variety of possible answers **Compared to NHQDR:** Both criteria sets include importance/relevance and balance across sites of care/flexibility. This study's criteria set also includes precision and discriminating power, while the NHQDR set does not. Both frameworks considers equity, efficiency, coordination of care, and access to care.	
Lawthers, 1995[71] US	**Setting:** Ambulatory care quality **Intended use:** N/A **Prioritization process:**Used performance measure framework. Data collection: Nurse reviewers used an interactive software program, written in Paradox, to collect data from photocopies of the office records. Chose to limit data collection to information at the end of a particular branch, thus only data needed to create a performance rate are collected. Approx 300 physicians per state were randomly sampled from a listing of all Medicare physicians in each state and invited to submit records for review. Invited physicians were mailed a list of 25 patient names, randomly selected from among	**Eligibility:** N/A **Nature of the measures:** Process : Rendering preventive or screening services,Outcome : Blood glucose > 250 with symptoms of diabetes mellitus,Unclear : Not clear if there are other types of measures - there is a broad range but it is not listed anywhere **Criteria definition:** Be quality oriented and clinically useful = focus on the quality of health care in relation to particular patient characteristics and that relate to specific actions that physicians can control Produce rates of performance for physician groups = instead of finding "bad apples," using rates focuses quality improvement efforts on group patterns of care and on moving the mainstream of performance rather than sanctioning outliers	Be quality oriented and clinically useful Produce rates of performance for physician groups Be developed with physical input Be evaluated for reliability and validity

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	their Medicare patients. Twenty seven percent of those invited to participate submitted photocopies of their medical records for review. Data from 4635 office records were collected over a 5 month period by specially trained nurse reviewers at each study state PRO. At the conclusion of data collection, a computer program calculated the acceptable performance rates for each item, indicator, and function. Summary rates were first calculated at the patient level and then averaged across all patients of the physician. Conduct evaluation -- process was used to assess validity involved in structure implicit peer review of the criteria; that is, a physician, following a protocol, judged the quality of the criteria as they applied to a particular case. In this review, the peer reviewer is asked primarily to evaluate the criteria and the results of performance measurement, not the physician being reviewed. **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	Be developed with physical input = be clinically detailed in order to be useful, the measures should be developed in an open and interactive process involving physicians Be evaluated for reliability and validity = evaluation of reliability and validity of measures **Compared to NHQDR:** Both criteria sets include validity and reliability. The criteria set in this study includes: Be developed with physician input; Produce rates of performance for physician groups; Be quality oriented and clinically useful, while the NHQDR does not.	
Lee, 2007[72] Korea	**Setting:** Korea nursing quality of care in hospitals **Intended use:** N/A **Prioritization process:**Delphi technique modified for this study was used to gain a consensus from Korean nursing experts. Three rounds of data collection from all participants was undertaken. In the first data collection, the sensitivity of 260 NOC	**Eligibility:** Outcome indicators **Nature of the measures:** Outcome : Vital signs status, Fall prevention, etc. **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include usability and sound measure available. The criteria in this study includes "To what extent do you think that each	Sensitive to nursing care in Korean hospital settings Most useful nursing outcomes for the evaluation of nursing care regarding their observability and measurability

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	nursing outcomes was examined, and more highly nursing sensitive ones were selected. In the second and third data collection phases, nursing outcomes which are most useful for the evaluation of nursing care were selected. **Context:** N/A **Engagement:** Yes Delphi technique modified for this study was used to gain a consensus from Korean nursing experts. **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	of the following nursing outcomes in NOC is sensitive to nursing care in Korean hospital settings?", while the NHQDR does not.	
Lester, 2010[73] UK	**Setting:** Healthcare quality of care **Intended use:** National Institute for Health and Clinical Excellence **Prioritization process:**Not reported **Context:** N/A **Engagement:** Yes From 2005 to 2009, new indicators in each QOF area were developed by a group of appointed primary care academic experts (the Expert Panel), supported by a group of clinicians who also had interested in that area **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Outcome,Unclear : Not reported **Criteria definition:** Acceptability = Is acceptable to both those being assessed and those undertaking the assessment Attributable = Achievement of the aspect of care defined by an indicator should be 100% under the control of those being assessed Feasibility = Valid and reliable consistent data are available and collectable Reliability = Minimal measurement error, reproducible findings when administered by different raters (inter-rater reliability) Sensitivity to change = Has the capacity to detect changes in quality of care, to discriminate between and within subjects Predictive value = Has the capacity to predict quality of care outcomes	Acceptability Attributable Feasibility Reliability Sensitivity to change Predictive value Relevance

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Relevance = Is in an area where there's a recognised gap between actual and potential performance **Compared to NHQDR:** Both criteria sets include feasibility, validity, reliability, and relevance (importance/improvability). The QOF criteria also includes acceptably, attributable, sensitivity to change, and predictive value, while the NHQDR criteria set does not.	
Levitt, 2010[10][9] Canada	**Setting:** Ontario, Canada (or other countries) primary care/family practice quality of care **Intended use:** N/A **Prioritization process:**The Quality program (a collaborative group from McMaster University and the Ontario College of Family Physician) team developed and tested the program and the original Quality Tool in a number of phases. In 2003-2005, the team reviewed the national and international literature on quality assessments in family practice/primary care, conducted focus-group interviews, environmental scans and teleconferences with patients and practitioners, and visited sites in the United Kingdom, Australia, New Zealand and Toronto, Canada that operate quality programs. The information guided the process for the Quality program and tool development. The project team was assisted by a steering committee composed of primary care providers, administrative staff and patients/consumers, a number of consultants and an advisory committee of key stakeholders. A modified Delphi process, conducted in 2008-2009 on the Indicators, led to a complete rewrite of the Quality Tool in 2009-2010. **Context:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure : Patients can reach the practice by telephone, email and/or other electronic means; clinical team provides access to 24-hour care, 7 days a week; practice team follows infection-control guidelines,Process : Cancer screenings,Outcome : Smoking cessation, alcohol, diet and exercise; stroke or transient ischemic attacks; asthma,Patient experience : Practice team encourages patient feedback and suggestions **Criteria definition:** Legal and safety: required by law Essential: required to demonstrate best practice Desirable: required to demonstrate additional quality **Compared to NHQDR:** The Quality Family Tool criteria are not reported, and so it is not clear what similarities and differences are between the two criteria sets. Both frameworks have similar components including equity, efficiency, access, effectiveness, timeliness, safety, and patient-centeredness.	Legal and safety Essential Desirable

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Engagement: Yes See Process of development field above **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Unclear Not reported		
Levitt, 2014[74] Canada	**Setting:** Primary care quality of care **Intended use:** N/A **Prioritization process:**A systematic comparison of indicators in the Quality Tool with those in other local and international tools to determine common indicators to include as valid in the Quality Tool. A Delphi process was used to help reach consensus for inclusion of any indicators that were not included in the comparison exercise. **Context:** N/A **Engagement:** Yes three family physicians and three administrators, two nurses, a social worker, a dietician and a patient **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) primary care **Validity testing status:** Not tested	**Eligibility:** N/A **Nature of the measures:** Structure : 1, 2,Process : 3, 4 **Criteria definition:** Value added = The indicator is value added: it reflects an area of assessment that is not covered by any other process. Measurable = The indicator is measurable at the patient, practice or population level and changes in the indicator can be clearly identified and compared over time. Standard = The indicator's criteria would be considered a standard for family practice, including what is formally required by law. Important = The indicator reflects an important or emerging issue that impacts on primary health care or primary health care delivery and provides information that can be used to inform policy decisions or change the behaviour of health service providers. **Compared to NHQDR:** The criteria includes value added and measurable, similar to the 2010 criteria. The criteria also includes importance, similar to the 2001 and current NHQDR criteria. The criteria includes "standard", which is not included in any other the other three sets of NHQDR criteria.	Value added Measurable Standard Important
Ludlow, 2022[76] Canada	**Setting:** Community-based health care quality **Intended use:** N/A **Prioritization process:**Modified Delphi informed conceptualization and prioritization of indicators. Formative research identified evaluation framework elements (triple aim, global measures, and impact), health system levels (tiers), and potential CBHC indicators (n = 461). Two Delphi rounds were held. Round 1,	**Eligibility:** N/A **Nature of the measures:** Structure : Access to integrated primary health care,Process : Hospital admissions and readmissions,Outcome : Mortality,Patient experience : Patient and family experience and satisfaction **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include applicability to the general population. The CBHC criteria set includes: Potential integration across program	Health System Outcomes (high-level measures): 1. Resonate with the public 2. Potential integration across program areas and inclusion of community resources 3. Ability to be benchmarked nationally/internationally 4. Targets typically achievable in 3-5 years

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	panelists independently ranked indicators on CBHC relevance and health system tiering. Results were analyzed by coding agreement/disagreement frequency and central tendency measures. Round 2, a consensus meeting was used to discuss disagreement, identify Tier 1 indicators and concepts, and define indicators not relevant to CBHC (Tier 4). Post-Delphi, indicators and concepts were refined, Tier 1 concepts mapped to the evaluation framework, and indicator narratives developed. Three stakeholder consultations (scientific, government, and public/patient communities) were held for endorsement and recommendation. **Context:** N/A **Engagement:** Yes Consulted to endorse and capture feedback for next steps **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied to different context	areas and inclusion of community resources; Ability to be benchmarked nationally/internationally; Targets typically achievable in the first 3-5 years; Tightly linked to CBHC program areas; Focus on proven drivers of health system outcome measures; Mostly focus on proven structure and process; Disease pathways that have most impact on the health of the population and the health system (cost/resources); Linked to CBHC program areas, but are not health system outcomes or strategic measures; May be focused on individual program level; and the NHQDR does not. Both frameworks include value of care and access to care.	Strategic Measures (program-level measures): 1. Tightly linked to CBHC program areas 2. Focus on proven drivers of health system outcome measures 3. Mostly focus on proven structure and process 4. Disease pathways that have most impact on the health of the population and the health system (cost/resources) 5. Targets typically achievable in the first 3 years Tactical/Transactional Measures (CBHC relevant, but not Tier 1 or 2): 1. Linked to CBHC program areas, but are not health system outcomes or strategic measures 2. May be focused on individual program level Not CBHC--Specific (Does not seem to be related to CBHC or any of the CBHC or any of the CBHC program areas)
MacLean, 2018[77] US	**Setting:** US health care performance **Intended use:** Performance Measurement Committee of the American College of Physicians **Prioritization process:** Using a modified version of the method developed at RAND and UCLA for evaluating the benefits and harms of a medical intervention, the American College of Physicians (ACP) criteria were applied to the measures included in the Medicare Merit-based Incentive Payment System (MIPS)/ Quality Payment Program (QPP). Authors identified and rated the validity of 86 that the committee considered relevant to ambulatory general internal medicine.	**Eligibility:** N/A **Nature of the measures:** Process : Stroke rehabilitation,Outcome : No example provided, but outcome measures is mentioned as a type that could be developed **Criteria definition:** Meaningful clinical impact = Implementation of the measure will lead to a measurable and meaningful improvement in clinical outcomes High impact = Measure addresses a clinical condition that is high-impact (e.g., high prevalence, high morbidity or mortality, high severity of illness, and major patient or societal consequences) Performance gap = Current performance does not meet best practices, and there is opportunity for improvement	1. Importance: Meaningful clinical impact High impact Performance gap 2. Appropriate care: Overuse Underuse Time interval 3. Clinical evidence base: Source Evidence 4. Measure specifications: Clarity--numerator and denominator clearly defined Clarity--all components necessary to implement measure clearly defined

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Context: N/A **Engagement:** Yes Experts doing assessment of the measures in the RAND-UCLA appropriateness panel **Evidence-based:** No **Defined population:** No (target unclear) Not clearly defined, but population reads as US health care performance **Validity testing status:** Not tested No indication that this has been tested empirically	Overuse = Measure will promote stopping use of a test or treatment in general population or individuals where the potential harms outweigh the potential benefits Underuse = Measure will encourage use of a test or treatment in general population or individuals in whom the potential benefits outweigh the potential harms Time interval = Time interval to measure the intervention is evidence-based Source = Evidence forming the basis of the measure is clearly defined with appropriate references Evidence = Evidence is high-quality, high-quantity, and consistent and represents current clinical knowledge Clarity = All components necessary to implement measure clearly defined (for process measures, numerator includes a specific action that will benefit the patient, and denominator includes well-specified exclusions; for outcome measures, numerators detail an outcome that is meaningful to the patient and under the influence of medical care; denominator includes well-specified and clinically appropriate exceptions to eligibility for the measure) Validity = The measure is correctly assessing what it is designed to measure, adequately distinguishing good and poor quality Reliability = Measurement is repeatable and precise, including when data are extracted by different people Risk adjustment = Risk adjustment is adequately specified for outcome measures Attribution = Level of attribution specified in the measure is appropriate (measure ties the outcomes to the appropriate unit of analysis) and is clearly stated Physician's control = Results of the measure provide information that will help the physician to improve care Usability = Data collection is feasible and burden is acceptable Burden = Data collection is feasible and burden is acceptable **Compared to NHQDR:**	Validity Reliability Risk adjustment 5. Measure feasibility and applicability: Attribution Physician's control Usability Burden

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Both criteria sets include reliability, validity, importance, scientific soundness, feasibility, usability, applicability to general population, at least some data, and improvability. The criteria in the current study include "Overuse: Measure will promote stopping use of a test or treatment in general population or individuals where the potential harms outweigh the potential benefits." "Underuse: Measure will encourage use of a test or treatment in general population or individuals in whom the potential benefits outweigh the potential harms." "Clarity--numerator and denominator, and all components necessary to implement the measure clearly defined." "Risk adjustment is adequately specified for outcome measures." "Physician's control: Performance measure addresses an intervention that is under the influence of the physician being assessed. " "Burden: Data collection is feasible and burden is acceptable (low, moderate, or high)", while the NHQDR does not.	
Mainz, 2004[78] Denmark	**Setting:** Danish National Health System quality of care **Intended use:** N/A **Prioritization process**:The elements included in this project emphasize: (i) problem identification and priority setting; (ii) development of evidence-based indicators and standards: Indicators and standards should be based on the scientiWc literature to assure the highest strength of evidence. If there is no scientific evidence available and the clinical problem in relation to the disease is very important, indicators and standards are determined by consensus among experienced and competent clinical experts. For each disease, six to 10 indicators are determined relating to the structure, process, and outcome of care; (iii) data collection; (iv) data analyses, evaluation, and interpretation; (v) feedback to providers and managers; (vi) audit; (vii) implementation of quality improvements; and (viii) public release of data. **Context:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure : Structure indicators assess the characteristics of the health care system that affect the system's ability to meet the health care needs of individual patients or a community (e.g. the nurse:bed ratio in a hospital),Process : Proportion of patients who undergo a CT/MRI scan,Outcome : 30 days and 3, 6, and 12 months mortality **Criteria definition:** Structure indicators = assess the characteristics of the health care system that affect the system's ability to meet the health care needs of individual patients or a community (e.g. the nurse:bed ratio in a hospital) Process indicators = assess what the provider did for the patient and how well he or she did it (e.g. proper diagnostic approach to symptoms) Outcome indicators = assess the infuence of the health care delivery process on the individual's health (e.g. morbidity and mortality) **Compared to NHQDR:** Both criteria sets include importance and scientific soundness. There is no formal list of criteria in the Danish National Indicator Project; authors note that they should be based on scientific literature, and if not available, the clinical problem should be very important, in which case indicators and standards will be determined by consensus among experienced and competent clinical experts. The NHQDR also has many more criteria not included in the DNIP.	Indicators and standards should be based on the scientific literature to assure the highest strength of evidence. If there is no scientific evidence available and the clinical problem in relation to the disease is very important, indicators and standards are determined by consensus among experienced and competent clinical experts. For each disease, six to 10 indicators are determined relating to the structure, process, and outcome of care.

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	Engagement: Yes Clinicians and managers receive continuous feedback of results (analyzed, evaluated, and interpreted at the national, regional, and local level at hospital and clinical units). A structured audit process is initiated in order to explain the results, to pr **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Implementation in the counties requires close cooperation between the Coordinating Secretariat, the units and the coun- ties, regarding both the process of data collection and the interpretation of data. To optimize this cooperation, a test of logistics a		
Marshall, 2004[80] Multiple countries	**Setting:** OECD healthcare quality of care **Intended use:** N/A **Prioritization process:**Discussion among international panel sought to identify indicators to capture the core components of care in each of the sectors, regardless of the institutional setting in which those components are provided. **Context:** N/A **Engagement:** Yes International expert panel used a structure review process and selected a set of 27 indicators **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Process : HIV screening for prenatal patients,Outcome : Number of abortions **Criteria definition:** Impact on health = what is the impact on health associated with this problem? does the measure address areas in which there is a clear gap between the actual and potential levels of health? Policy importance = are policymakers and consumers concerned about this area? Susceptibility to being influenced by the health care system = can the health care system meaningfully address this aspect or problem? Does the health care system have an impact on the indicator independent of confounders like patient risk? Will changes in the indicator give information about the likely success or failure of policy changes? Face validity = does the measure make sense logically and clinically? The face validity of each indicator is based on the basic clinical rationale for the indicator, and on past usage of the indicator in national or other quality reporting activities.	1. Importance: Impact on health Policy importance Susceptibility to being influenced by the health care system 2. Scientific soundness: Face validity Content validity

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ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Content validity = does the measure capture meaningful aspects of the quality of care? **Compared to NHQDR:** Both criteria sets include importance, scientific soundness, and validity. Both frameworks address healthcare delivery in some way, and includes types of care and care coordination.	
Matos, 2021[81] Portugal	**Setting:** Portuguese public hospitals quality of care, efficiency, access, and financial **Intended use:** N/A **Prioritization process:**The choice of variables considered the following criteria: (a) a comprehensive literature revision, (b) availability and quality of the data for the sample and time interval considered, and (c) relevance for the study in question. Variables were clustered into four groups: access, efficiency and productivity, financial, and quality. One should avoid redundant information as well as an excessively high number of variables. They should be enough to explain hospital performance. In this way, the correlation between variables was analyzed to verify the association between them and redundancy. Variables exhibiting high correlation and causal relationships were removed. Thus, each of the remaining variables are guaranteed to bring new and non-redundant information into the model. **Context:** The benefit of the doubt (BoD) is a non-parametric weighting method that aims to maximize the relative composite indicator value of each decision-making unit (DMU). A well-known issue of BoD-based ranking of DMUs is the rank reversal problem when DMUs are **Engagement:** No Model suggested by authors	**Eligibility:** N/A **Nature of the measures:** Structure : Waiting time before surgery,Process : Rate of surgeries within time, drug expenses per standard patient,Outcome : Cesarean section rate **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance/relevance for the study in question, as well as "at least some state data/ availability and quality of the data for the sample and time interval considered. The criteria set for the Portuguese hospitals includes "a comprehensive literature revision", while the NHQDR does not. Both frameworks include equity, safety, effectiveness, efficiency, access, timeliness, types of care, and health systems infrastructure capabilities.	Comprehensive literature revision Availability and quality of the data for the sample and time interval considered Relevance for the study in question

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Evidence-based: Empirically based **Defined population:** Yes (framework target described in detail) Portuguese public hospitals **Validity testing status:** Tested Applied in different context		
Mattke, 2007[82] US	**Setting:** Healthcare quality of care **Intended use:** N/A **Prioritization process:** Initially, semi-structured interviews were conducted with all participants about their current policies and procedures for maintenance of quality measures, experiences with those policies and procedures, and plans to modify them in the near future. Participants were asked to reflect on desirable properties for a comprehensive system for measures maintenance. Using content analysis, commonalities were identified in both actual practices and theoretical requirements across all respondents and a briefing document was prepared to summarize findings as the basis for the panel discussions. Next, all interviewees were invited to participate in a series of discussions by conference call to discuss the findings and to arrive iteratively at consensus recommendations for a framework for maintenance of quality measures. A series of four 2-h calls were conducted. After each call, the summary document was updated to reflect the progress towards consensus and it was circulated again among the group. The panel discussions were structured to provide input towards a framework for measures management that consists of four elements: key functions, decision criteria,	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance, scientific soundness, feasibility, and usability. The NHQDR criteria set includes many other criteria that were not used in this study's criteria set.	Relevance/importance Scientific soundness Feasibility, including measures specifications Usability/actionability

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	disposition decisions and recommended timeframes. **Context:** N/A **Engagement:** Yes Conducted enquiry into current practices and policies for measures maintenance, via interviews and panel discussions, to identify common characteristics and to formulate key elements of a measures maintenance system. Key reps of US orgs developing nationa **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication that this has been tested empirically		
McGlynn, 1998[85] US	**Setting:** Health care/ clinical performance **Intended use:** N/A **Prioritization process:** Four steps required to develop a clinical performance measure that is suitable for making comparisons among health delivery systems are discussed: (1) choosing clinical areas to measure (2) selecting performance indicators within each area (3) designing specifications for consistent implementation of a measure: define the indicator, identify the target population for the measure, determine the risk-adjustment strategy, identify data sources, write data extraction or collection specifications, write specifications for scoring the measure (4) evaluating the scientific strength of a measure: reliability of the measure, validity of the measure, interpretability of the results (statistical analysis, calibration	**Eligibility:** N/A **Nature of the measures:** Process,Outcome,Patient experience : Satisfaction with care **Criteria definition:** Importance of the condition = contributes significantly to morbidity and mortality, is associated with high rates of utilization, is costly to treat Potential for quality improvement = conditions should be selected where there is evidence that the quality of care is either variable or substandard; greater priority should be given to areas with the potential for substantial improvement. Degree to which health care professionals control the mechanisms for improving care = quality measures are most useful when the process or outcome being evaluated can be influenced by ac- cepted health care practices undertaken by plans or providers. Strength of scientific evidence (validity and reliability was captured under this criteria) = How many studies have been conducted that are related to this indicator? What methods were used in these studies? How consistent were the findings? Cost-effectiveness of the indicator process = Because quality measurement is believed to encourage health plans to improve	Choice of areas for measurement/assessment: 1. Importance of the condition 2. Potential for quality improvement 3. Degree to which health care professionals control the mechanisms for improving care Process indicators: 1. Strength of scientific evidence (validity and reliability was captured under this criteria) 2. Cost-effectiveness of the indicator process Outcome measures: 1. Adequacy of controls for differences in case-mix 2. Adequacy of controls for other covariates

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	of measures, effective presentation of information) **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Tested Applied in a different context (application of the steps to developing measures of quality of hypertension was provided)	performance, indicators that represent cost-effective methods for achieving optimal outcomes are preferred. Adequacy of controls for differences in case-mix = The purpose of case-mix or severity-of-illness adjust- ment is to allow for a "fair" comparison of health outcomes and to ensure that any observed differences can be attributed to the health plans' interventions and not to differences between the enrolled populations. Adequacy of controls for other covariates = Other factors, or covariates, might also contribute to a health plan's performance results. For example, a principal method of treating hypertension is use of medications. **Compared to NHQDR:** Both criteria sets include importance, improvability, scientific soundness, validity, and reliability. The criteria is this study also included: Adequacy of controls for differences in case-mix; Adequacy of controls for other covariates; Cost-effectiveness of the indicator process; the degree to which health care professionals control the mechanisms for improving care, while the NHQDR does not.	
McGlynn, 1998[84] US	**Setting:** Healthcare performance **Intended use:** The Joint Commission **Prioritization process:**Not reported **Context:** N/A **Engagement:** No Suggested by author **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication that this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Process,Outcome **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance and scientific soundness. The Joint Commission criteria includes: evidence that a link exists between the processes and outcomes of care; evidence that quality is variable or substandard currently; health plans and providers can have an effect on the process or outcome, while the NHQDR criteria does not.	The condition has significant impact on morbidity and/or mortality The link between the measured processes and outcomes of care has been established empirically Quality in this area is variable or substandard currently Health plans and/or providers can take clinically sensible actions to enhance performance on the measure
Mears, 2011[86] Multiple countries	**Setting:** Healthcare quality of care **Intended use:** European Partnership for Supervisory Organizations **Prioritization process:**A framework was developed to classify indicators, using four sets of criteria: conceptualization of quality, Donabedian definition (structure, process, outcome), data type (derivable, collectable from routine sources, special	**Eligibility:** N/A **Nature of the measures:** Structure : Process in place that identify events that may lead to avoidable patient harm,Process : Compliance with best practice care pathways and procedures,Outcome : Mortality rates for stroke, AMI, fractured neck of femur, 30-day readmission rates **Criteria definition:** N/A **Compared to NHQDR:**	Conceptualization of quality Donabedian definition (structure, process, outcome) Data type (derivable, collectable from routine sources, special collections, samples) Indicator use (judgement singular, judgement as part of framework, benchmarking, risk assessment)

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	collections, samples) and data use (judgement (singular or part of framework) benchmarking, risk assessment). **Context:** N/A **Engagement:** No Model suggested by European Platform for Supervisory Organizations working group **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied to different context	Both criteria sets includes "at least some data available". The ESPO criteria set includes "conceptualization of quality", "Donabedian definition", and "Indicator use (judgement singular, judgement as part of framework, benchmarking, risk assessment), while the NHQDR set does not. Both frameworks addresses healthcare, and includes safety, effectiveness, and efficiency.	
Meltzer, 2014[87] Meltzer, 2010[152] US	**Setting:** Healthcare performance **Intended use:** N/A, but authors used AHRQ quality indicators with readily available data on the benefits of indicator reporting as an example. **Prioritization process:** N/A **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Tested Authors applied this approach to a set of 13 AHRQ quality indicators as an example in this article	**Eligibility:** N/A **Nature of the measures:** Process : % of people ages 15-44 who ever received an HIV test outside of blood donation,Outcome : % of adults with diagnosed diabetes with most recent blood pressure <140/80 mmHg,Patient experience : No example provided, but authors state some indicators measure patient experience/satisfaction **Criteria definition:** N/A **Compared to NHQDR:** There aren't clear similarities between the two criteria sets. The approach in this article is a conceptual and methodological framework to quantify the improvements in population health that may result from reporting health care quality indicators.	Impact on population health (improve the length and quality of life of the U.S. population
Michel, 2020[88] France	**Setting:** Hospital quality of care **Intended use:** N/A **Prioritization process:** Development of method: An expert group used the RAND/UCLA appropriateness rating method for selecting the criteria. This rating method is a modified Delphi technique, comprised of literature review, multidisciplinary panel meeting and rounds of anonymous rating. This method has been commonly used to define priorities in public health and specifically	**Eligibility:** N/A **Nature of the measures:** Structure : Multidisciplinary team meeting in oncology (quality of meeting report),Process : Care quality of chronic hemodialysis patients (monitoring of phosphocalcic balance, serological surveillance of hepatitis),Outcome : Prevention and care of postpartum hemorrhage (prevention of hemorrhage during delivery),Patient experience : Patient satisfaction (satisfaction/expereince of patients hospitalized in medicine, surgery and obstetrics more than 48h) **Criteria definition:** N/A	Clarity Evidence Importance for the healthcare system Validity Risk adjustment Discriminatory power Dynamics of change Delays related to data production Barriers to implementation Potential risks/side effects Benefit/ability to take decision Providers influence on results/gaming

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	in the field of quality indicators development. Test of method: Ten indicators were selected by the commissioning institutions and the workgroup for the test. **Context:** N/A **Engagement:** Yes Expert workgroup used the RAND/UCLA appropriateness rating method for selecting criteria **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Tested and applied on 10 QIs	**Compared to NHQDR:** Both criteria sets include: validity, importance, scientific soundness, feasibility, usability, improvability, and applicability to national priorities. This criteria set also includes: Providers influence on results/gaming; Potential risks/side effects; Risk adjustment; Discriminatory power; Dynamics of change; Delays related to data production, while the NHQDR criteria set does not.	
Nadzam, 1993[90] US	**Setting:** Health system performance **Intended use:** Joint Commission **Prioritization process:**Sets of indicators, each set related to specific important health care functions such as preoperative care, are established by expert tasks forces and are then subject to two phases of testing. Alpha testing addresses face validity and feasibility of data collection and may result in indicator revision. In the beta phase, a large group of organizations test the indicators for validity, reliability and usefulness in improving performance. **Context:** This process has been used by the Joint Commission to assess indicators. **Engagement:** Yes Sets of indicators, each set related to specific important health care functions such as preoperative care, are established by expert task forces and are then subject to two phases of testing **Evidence-based:** No **Defined population:** No (target unclear)	**Eligibility:** N/A **Nature of the measures:** Structure,Process,Outcome **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include validity, reliability, and usability. The Joint Commission criteria set includes more specific criteria regarding validity and reliability: The ability of a variety of health care organizations to collect and transmit indicator data to the Joint Commission; The capability of the Joint Commission to analyze these data and provide timely feedback to health care organizations; Possible methods to incorporate indicator data into the accreditation process; The ability of health care organizations to integrate new indicators into their monitoring activities; The reliability of the data elements; The reliability and validity of the indicators for identifying opportunities to improve patient care and services.	Alpha testing: Face validity Feasibility Beta testing: The ability of a variety of health care organizations to collect and transmit indicator data to the Joint Commission The capability of the Joint Commission to analyze these data and provide timely feedback to health care organizations Possible methods to incorporate indicator data into the accreditation process The ability of health care organizations to integrate new indicators into their monitoring activities The reliability of the data elements The reliability and validity of the indicators for identifying opportunities to improve patient care and services

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Validity testing status: Tested This process has been used by the Joint Commission		
NASE M, 2002[92] US	**Setting:** Healthcare quality of care **Intended use:** AHRQ **Prioritization process:**Not reported **Context:** N/A **Engagement:** Unclear Not reported, but stakeholders were involved in the development of the report **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this model has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Structure : Insurance issues such as the availability of Medicaid coverage for low income seniors, the proportion of people with insurance that covers primary/preventive care and medicines, and the proportion of people whose insurance includes co-payments and/or deductibles,Process : Proportion of adolescents with up-to-date immunization status,Outcome : Proportion of HIV-infected individuals who know their serostatus **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include applicability to the general population and improvability. This criteria set has a focus on disparities, while the current NHQDR criteria set doesn't necessarily do so. This criteria set includes the following that the current NHQDR set does not: They incorporate an expanded definition of health. This is particularly important for mental health since it is an important co- morbidity for chronic diseases such as diabetes and etiologic in much care-seeking behavior. They should represent issues that affect all populations, but that affect minority populations in an important way. For disease- specific measures, priority should be given to those conditions that were the focus of the 1998 Federal Initiative to Eliminate Racial and Ethnic Disparities in Health. They should capture disparities that are known to exist. They are particularly important for specific populations, even if they are less salient to Whites. They fill gaps in the quality framework, including the continuum of care, attributes of quality, or care over the lifespan. They reflect patient-centered or community-centered aspects of access. They should add important information beyond core measures. Both frameworks address healthcare delivery, and include the domains safety, effectiveness, patient centeredness, and timeliness, as well as having equity as a crosscutting dimension.	They should represent issues that affect all populations, but that affect minority populations in an important way. For disease- specific measures, priority should be given to those conditions that were the focus of the 1998 Federal Initiative to Eliminate Racial and Ethnic Disparities in Health. They should cover the lifespan. They should capture disparities that are known to exist. They should add important information beyond core measures. There is a strong likelihood that the health of minority populations would improve if the focus of measurement were addressed. It is also possible that addressing some foci would improve health for all populations without decreasing disparities. Because the primary aim is improved health, measures should not be discarded for this reason. They are particularly important for specific populations, even if they are less salient to Whites. They fill gaps in the quality framework, including the continuum of care, attributes of quality, or care over the lifespan. They reflect patient-centered or community-centered aspects of access. They incorporate an expanded definition of health. This is particularly important for mental health since it is an important co-morbidity for chronic diseases such as diabetes and etiologic in much care-seeking behavior.
National al	**Setting:** Population health	**Eligibility:** N/A	1. Measurable 2. Current baseline data

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Acade mies of Scienc es, Engine ering, and Medici ne, 2019[91] US	**Intended use:** HHS Healthy People Initiative **Prioritization process:** Not reported **Context:** This is a new iteration of the Healthy People initiative, which has been used in the past to select health indicators. **Engagement:** No Suggested by authors and team **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Nature of the measures:** Structure : Not reported in this report, but an example is: Increase the number of community organizations that provide prevention services,Process : Not reported in this report, but an example is: Increase the proportion of females who get screened for breast cancer,Outcome : Not reported in this report, but an example is: reduce the rate of infant deaths **Criteria definition:** Measurable = the core objective must be measurable by the data cutoff for inclusion in HealthyPeople 2030 (HP2030), which is mid-2019 Current baseline data = the core objective must reasonably be expected to have a baseline using data no older than 205, and at least 2 additional data points during the HP2030 decade National importance = the objective must be of national importance; to meet the "national importance" criterion, objectives should have a direct impact or influence on health, broad and comprehensive applicability, a substantial burden, and they should address a national health priority Direct impact or influence = does the objective address an outcome or preventive/risk factor that has a direct impact on population health? Broad and comprehensive applicability = does this objective address a broad health concern or topic that is applicable to a large part of the population, as opposed to being limited to more narrowly defined groups? Substantial burden = does this objective address a health concern that represents a substantial impact or potential impact on the health or well-being of an individual or on a population? National (not just federal) public health priority = does this objective address a public health priority of the HHS, national prevention initiatives, other national indicator projects, and efforts at the state, local, and tribal level across the country? Evidence-base = the objective should have a known evidence-base, and identified evidence-based interventions to improve outcomes; the effectiveness of the objectives was rated based on the scale used in HP2020 to rate evidence-based resources on the website	3. National importance 3a. Direct impact or influence 3b. Broad and comprehensive applicability 3c. Substantial burden 3d. National (not just federal) public health priority 4. Evidence-base 5. Health equity and disparities

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Health equity and disparities = the objectives should address health disparities and/or support achieving health equity; objectives are also considered for inclusion, based on the expectation that the data source is able to track the following population level data: sex, race/ethnicity, age, educational attainment, family income, health insurance status, geographic location or region, marital status, sexual orientation, gender identity, disability status. **Compared to NHQDR:** Both criteria sets include importance, scientific soundness, applicability to the general population, at least some data, sound measure available, applicability to national priorities, population equity, and geographic and health systems equity. The NHQDR has several other criteria that are not included in the HP2030 set.	
National Association of County and City Health Officials, 2018[93] US	**Setting:** Public health **Intended use:** N/A **Prioritization process:**Not reported **Context:** N/A **Engagement:** No Suggested by authors **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication that this been tested empirically	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported **Criteria definition:** Relevance = is the measure relevant to the strategic goals and objectives? Importance = does the measure assess and important aspect of the objective (e.g., delivery process, customer satisfaction)? Clarity = does the measure describe what is being measured to users? Is there room for misinterpretation? Feasibility = is data collection feasible and likely to produce good data? Uniqueness = is the measure duplicative or overlapping with other measures? Manipulability = does the measure encourage staff to maniple data (e.g., tracking # of complaints resolved may discourage preventing complaints in the first place) Program influence = is the influence a program has over an outcome balanced with the need to track key outcomes? Longevity = can these data be measured and compared overt time? **Compared to NHQDR:** Both criteria sets include importance, feasibility, and usability. The NACCHO criteria set includes: Uniqueness; Manipulability; Longevity; Program influence, while the NHQDR criteria does not. The	Relevance Importance Clarity Feasibility Uniqueness Manipulability Program influence Longevity

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		NACCHO criteria set is used to select/prioritize broad performance measures/indicators, while the NHQDR criteria is used to select/prioritize quality of care indicators for healthcare. Both frameworks include equity, access, and timeliness.	
National Health Center for Statistics, 2018[94] US	**Setting:** Healthy People core objectives **Intended use:** Healthy People **Prioritization process:**Not reported **Context:** N/A **Engagement:** Unclear **Evidence-based:** No **Defined population:** Yes (framework target described in detail) Healthy People addresses the US population **Validity testing status:** Not tested No indication that this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported **Criteria definition:** Evidence-based = Rate the objective based on the evidence that exists for the effective interventions to achieve the objective National importance: Direct impact or influence on health = N/A National importance: Broad and comprehensive applicability = N/A National importance: Substantial burden = N/A National importance: National (not just federal) public health priority = N/A National importance: Summary assessment = Based on the overall assessment of the responses to the four components of National Importance, does this objective meet the national importance criterion? Health equity and disparities = Does your objective address health equity and disparities by having population data broken down by any of these groups: sex, race/ethnicity, age, educational attainment, family income, health insurance status, geographic location or region, marital status, sexual orientation, gender identity, disability status? **Compared to NHQDR:** Both criteria sets include importance and scientific soundness. The Healthy People 2030 criteria includes "Does your objective address health equity and disparities by having population data broken down by any of these groups: sex, race/ethnicity, age, educational attainment, family income, health insurance status, geographic location or region, marital status, sexual orientation, gender identity, disability status?" while the NHQDR does not.	Evidence-based National importance: Direct impact or influence on health National importance: Broad and comprehensive applicability National importance: Substantial burden National importance: National (not just federal) public health priority National importance: Summary assessment Health equity and disparities
National Health Ministers Bench	**Setting:** Health sector performance **Intended use:** Australian Health Minister; National Health Ministers' Benchmarking Working Group **Prioritization process:**Data collection (e.g., include National Minimum Data Set	**Eligibility:** N/A **Nature of the measures:** Structure : Proportion of beds accredited by Australian Council on Healthcare Standards,Outcome : Rate of hospital-acquired infection,Patient experience : Patient satisfaction	Validity of indicators, in terms of the degree to which they provide clear and direct information about the efficiency and effectiveness of the health sector The understandability of the indicators

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
marking Working Group, 1996[95] Australia	survey programs data; State and Territory health authorities were also requested to provide data regarding capital asset valuation and related material, and additional information on projects and activities related to the agreed performance indicators was also requested to illustrate indicators for which national data were not available). Survey was conducted on State and Territory health authorities aimed to evaluate the likely availability and quality of data for this report given current collection parameters. Working Group decided that only a small subset of the agreed indicators will be used for comparison purposes, and that the indicators be accompanied by a number of qualifying statements. **Context:** N/A **Engagement:** No Suggested by authors/Australian National Health Ministers' Benchmarking Working Group **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include validity, feasibility, and usability. The NHQDR has numerous other criteria that this report does not have. Both frameworks address health system/sector delivery, and include access, effectiveness (outcomes in the Australian framework), efficiency, and health systems infrastructure capabilities.	The ease and cost of the collection of the relevant data
National Health Performance Committee, 2001[96] Australia	**Setting:** Australia health and health system performance **Intended use:** National Health Performance Committee **Prioritization process:** N/A **Context:** N/A **Engagement:** Yes An NHPC workshop was held in Adelaide in July 2000 with over 40 people from a range of backgrounds to refine and improve the	**Eligibility:** N/A **Nature of the measures:** Structure : Number of general practitioner services per patient per region per year; proportion of GP practices registered for accreditation,Process : Breast cancer screening,Outcome : Deaths from suicide and self-inflicted injury **Criteria definition:** Be worth measuring = The indicators represent an important and salient aspect of the public's health or the performance of the health system.	Selection for Health Performance Indicators: 1. Be worth measuring 2. Be measurable for diverse populations 3. Be understood by people who need to act 4. Galvanise action 5. Be relevant to policy and practice 6. Measurement over time will reflect results of actions 7. Be feasible to collect and report

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	proposed framework. Written feedback was also widely requested and this feedback has informed deliberations about the framework or **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied in different context	Be measurable for diverse populations = The indicators are valid and reliable for the general population and diverse populations (i.e. Aboriginal and Torres Strait Islander peoples, rural/urban, socioeconomic etc). Be understood by people who need to act = People who need to act on their own behalf or on that of others should be able to readily comprehend the indicators and what can be done to improve health. Galvanise action = The indicators are of such a nature that action can be taken at the national, state, local or community level by individuals, organised groups and public and private agencies. Be relevant to policy and practice = Actions that can lead to improvement are anticipated and feasible – they are plausible actions that can alter the course of an indicator when widely applied. Measurement over time will reflect results of actions = If action is taken, tangible results will be seen indicating improvements in various aspects of the nation's health. Be feasible to collect and report = The information required for the indicator can be obtained at reasonable cost in relation to its value and can be collected, analysed and reported on in an appropriate time frame. Comply with national processes of data definitions = N/A **Compared to NHQDR:** Both criteria sets include reliability, validity, importance, feasibility, applicability to the general population, linkable to established indicator sets, balance across health conditions, improvability, population equity, and geographic and health systems equity. The NHPC criteria set includes: People who need to act on their own behalf or on that of others should be able to readily comprehend the indicators and what can be done to improve health; The indicators are of such a nature that action can be taken at the national, state, local or community level by individuals, organised groups and public and private agencies; Comply with national processes of data definitions; Reflect a balance of indicators for all appropriate parts of the framework (health status and outcomes, determinants of health, health system performance); Identify and respond to new and emerging issues; and Facilitate the use of data at the health industry service unit level for benchmarking purposes, while the NHQDR does not.	8. Comply with national processes of data definitions Selection Criteria for Sets of Performance Indicators: 1. Cover the spectrum of the health issue 2. Reflect a balance of indicators for all appropriate parts of the framework 3. Identify and respond to new and emerging issues 4. Be capable of leading change 5. Provide feedback on where the system is working well, as well as areas for improvement Additional Selection Criteria Specific to National Health Performance Committee Reporting: 1. Facilitate the use of data at the health industry service unit level for benchmarking purposes 2. Be consistent and use established and existing indicators where possible

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Both frameworks considers the domains effectiveness, access, safety, and efficiency.	
National Quality Forum, 2009[100] US	**Setting:** Efficiency of patient-focused healthcare **Intended use:** National Quality Forum **Prioritization process:**N/A **Context:** N/A **Engagement:** Yes Multistakeholder Steering Committee was convened to shepherd the work in developing the measurement framework **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Authors applied the measurement framework to two very different types of conditions (acute myocardial infarction and low back pain) to determine the applicability of the framework to those conditions, thus making the framework more likely to be generaliza	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported, but measure of efficiency was the focus on this report **Criteria definition:** Efficiency measurement is multidimensional = Judgments about efficiency should be based on a comprehensive set of measures that adequately portray performance in three domains: patient-level outcomes, cost and resource use, and processes of care. The choice of measures to inform judgments on efficiency should include consideration of potential leverage = Consideration should be given to those that have the highest likelihood of positively influence desirable patient outcomes at reasonable costs and that offer the greatest opportunity to spur system-level improvement Measures used to inform judgments on efficiency should promote shared accountability across providers and should be assigned to the smallest unit of accountability as technically feasible = The framework for efficiency measurement should address all levels within the healthcare system, including individual patients, independent healthcare professionals, provider organizations, and communities. Measures used to inform judgments on efficiency should respond to the need to harmonize measurement across settings of care = For existing measures, efforts should be made to reconcile measurement specifications/definitions among healthcare professionals (e.g. physicians, nurses) and across multiple settings (e.g., ambulatory, hospital, nursing home, home health, community, populations). Measures to inform judgments on efficiency should be used for benchmarking = When assessing efficiency of care either at the individual healthcare professional, provider organization, or system level, performance should be compared to, or indexed against, an appropriate benchmark. Public reporting of measures of efficiency should be meaningful and understandable to consumers and entities accountable for their care = N/A	Principle 1: Efficiency measurement is multidimensional Principle 2: The choice of measures to inform judgments on efficiency should include consideration of potential leverage Principle 3: Measures used to inform judgments on efficiency should promote shared accountability across providers and should be assigned to the smallest unit of accountability as technically feasible Principle 4: Measures used to inform judgments on efficiency should respond to the need to harmonize measurement across settings of care Principle 5: Measures to inform judgments on efficiency should be used for benchmarking Principle 6: Public reporting of measures of efficiency should be meaningful and understandable to consumers and entities accountable for their care Principle 7: Inappropriate care cannot be efficient Principle 8: The measurement framework should achieve its intended purpose and should be monitored for unintended consequences Principle 9: Measures to inform judgments on efficiency should be an integral part of a continuous learning system

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Inappropriate care cannot be efficient = Measures to inform judgments on efficiency should be capable of detecting misuse, overuse, and underuse of care within the episode timeframe. The measurement framework should achieve its intended purpose and should be monitored for unintended consequences = A measurement framework that is designed to inform judgments on efficiency should facilitate improving health and reducing the cost and burden of illness. Framework should be periodically evaluated to ensure its effectiveness. Measures to inform judgments on efficiency should be an integral part of a continuous learning system = In addition to assessing individual healthcare professionals, provider organizations, and system performance, efficiency measurement also should be designed for continuous learning to inform clinical practice measure development, policy, and the research agenda. **Compared to NHQDR:** Both criteria sets include usability, balance across sites of care, improvability, and sound measure available. The NQF criteria set includes: Should be based on a comprehensive set of measures that adequately portray performance in three domains: patient-level outcomes, cost and resource use, and processes of care; Should promote shared accountability across providers and should be assigned to the smallest unit of accountability as technically feasible; Should be capable of detecting misuse, overuse, and underuse of care within the episode timeframe; Should facilitate improving health and reducing the cost and burden of illness; and Should be designed for continuous learning to inform clinical practice, measure development, policy, and the research agenda, while the NHQDR does not. Both frameworks include value, effectiveness, patient-/family-centeredness, and efficiency.	
National Quality Forum, 2012[98] US	**Setting:** Disparities and cultural competency **Intended use:** National Quality Forum **Prioritization process:**The Committee developed a protocol to systematically screen and tag NQF-endorsed measures as disparities sensitive. The Committee identified first-tier criteria (prevalence, quality impact, and disparities quality gap)	**Eligibility:** N/A **Nature of the measures:** Structure : Mentioned as possible type of measure, but no example,Process : Fibrinolytic therapy received within 30 minutes of hospital arrival,Outcome : Coronary artery disease and medication possession ratio for statin therapy,Patient experience : Children who receive family-centered care (listens to patient/parent carefully, sensitive to family values/customs, etc.	First-tier criteria: 1. Prevalence 2. Quality impact 3. Disparities quality gap Second-tier criteria: 1. Care with a high degree of discretion 2. Communication-sensitive services 3. Social-determinant dependent

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	and second-tier criteria (care with a high degree of discretion, communication-sensitive services, and social-determinant dependent measures). The following six categories, recommended by the commissioned paper, were used as a categorization system to better assess the care settings or other factors represented by the final set of disparities-sensitive measures: practitioner performance; consumer surveys that measure patient experience; hospital, ambulatory care, or home health nursing home; ambulatory care sensitive conditions and management; cultural competency; patient-centered. All measures were further identified as system-based or provider-based, then cross-cutting or the potential to influence multiple measures. In addition, the measure type (structure, process, and outcome) was indicated. **Context:** N/A **Engagement:** No **Evidence-based:** No **Defined population:** Yes (framework target described in detail) Those affected by disparities **Validity testing status:** Not tested No indication that this has been tested empirically	**Criteria definition:** Prevalence = How prevalent is the condition among the minority population? Quality impact = How large is the gap in quality of care between the disadvantaged population and the group with the highest quality for that measure? Disparities quality gap = The influence a condition or topic has financially, publically, and on the community at large was evaluated. Care with a high degree of discretion = Measures that do not cite a clinical guideline, receiving two points and those that specifically cite a clinical guideline as part of the evidence receive 0 points. Communication-sensitive services = Performance measures were tagged when they matched one of the following NQF-endorsed framework domains and/or preferred practices: Cultural Competency Framework Domain: Patient-Provider Communication and the corresponding sub-domains and/or preferred practices.; Care Coordination Framework Domain: Communication and the corresponding sub- domains and/or preferred practices Social-determinant dependent = Performance measures were matched to social or behavioral aspects of health. Measures in the NQF portfolio that are within the direct "control sphere" of either healthcare delivery or public health as demonstrated by the specifications of the measure were given a score of 3 points; measures that address behavioral aspects of health were given a score of 2 points; and measures that address environmental aspects were given 1 point and measures that meet other social determinant indicators were given a score of 0. **Compared to NHQDR:** Both criteria sets include applicability to the general population, applicability to national priorities, population equity, and geographic and health systems equity. The NQF criteria set included Communication-Sensitive Services; Care with a High Degree of Discretion; and Social Determinant-Dependent Measures, while the NHQDR does not.	
National Quality	**Setting:** Healthcare quality of care (and disparities) **Intended use:** N/A **Prioritization process:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure,Process,Outcome **Criteria definition:** Importance to measure and report = the measure is evidence-based;	Importance to measure and report Scientific acceptability of measure properties Feasibility

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Forum, 2023[97] US	**Context:** N/A **Engagement:** No Model suggested by NQF **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication that the criteria have been tested empirically	demonstration of quality problems and opportunity for improvement; high priority; composite performance measures Scientific acceptability of measure properties = reliability; validity; if patient preference (e.g., informed decision making) is a basis for exclusion, there must be evidence that the exclusion impacts performance on the measure; if disparities in care have been identified, measure specifications, scoring, and analysis allow for identification of disparities through stratification of results; for composite measures, empirical analyses support the composite construction approach Feasibility = extent to which the specifications, including measure logic, required data that are readily available or could be captured without undue burden and can be implemented for performance measurement Usability and use = accountability and transparency; improvement; the benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists) Related and competing measures = the measure specifications are harmonized with related measures or the differences in specifications are justified; the measure is superior to competing measures (e.g., is a more valid or efficient way to measure) or multiple measures are justified Linked to gains in quality and health outcomes = N/A **Compared to NHQDR:** Both criteria sets include importance, scientific soundness/acceptability, feasibility, usability, and linkable to established indicators sets/ related and competing measures. The NQF also has "conditions for consideration" that need to be met before they move on to be evaluated against the aforementioned criteria, and the conditions include: validity and reliability (amongst other conditions not relevant to the current study). The NQF criteria set includes "linked to gains in quality and health outcomes", while the NHQDR does not.	Usability and use Related and competing measures Linked to gains in quality and health outcomes[141]
NHS, 1999[102]	**Setting:** Healthcare system performance **Intended use:** NHS **Prioritization process:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure : Unit costs, Process : Chronic case management (for asthma, diabetes, epilepsy); cancer	Attributable Important Avoid perverse incentives

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
NHS, 1998[10][1] UK	**Context:** N/A **Engagement:** Yes Consultation to revise the framework, and performance indicators for the framework **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied to a different context	screening,Outcome : 30 day preoperative mortality rate,Patient experience : Patients who wait more than 2 hours for emergency admission **Criteria definition:** Attributable = indicators should reflect health and social outcomes which are substantially attributable to the NHS through its roles as service provider, advocate for health and inter-agency partner Important = the indicators should cover an outcome which is relevant and important to policy makers, health professionals and managers (and which resonates with the concerns of the public) Avoid perverse incentives = an indicator should be presented in such a way that managers can act upon it without introducing perverse incentives. There should be no incentive to shift problems onto other organisations. Where this is the case, a counterbalancing indicator should be considered alongside. Robust = measurement of the indicator should be reliable and coverage of the outcome measured should be high, although sampling may be appropriate for some indicators. In particular, data should be robust at the level at which performance monitoring is undertaken. For example, if monitoring of Health Authority (HA) performance is the aim, the indicator should be measuring sufficient numbers of events so that HA values are not unduly subject to large random variations. In other words, the indicator should be reliable for the purpose for which it is used. Responsive = an indicator should be responsive to change and change should be measurable. It should not be an indicator where change will be so small that monitoring trends becomes difficult. Consideration should be given to whether the rate at which change can be expected to occur makes the indicator relevant for performance monitoring purposes. Usability and timeliness = data should be readily available within a reasonable timescale **Compared to NHQDR:** Both criteria sets include reliability, importance, usability, and data available regularly. The NHS criteria set includes: Should reflect health and social outcomes which are substantially attributable to the NHS through its roles as service provider, advocate for health and inter-agency partner; Avoid perverse indicators; Responsive to	Robust Responsive Usability and timeliness

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		change and change should be measurable, while the NHQDR does not. Both frameworks address healthcare, and include access, effectiveness, and efficiency; timeliness is include in the effective component in the NHS framework.	
NICE, 2019[51] UK	**Setting:** Healthcare quality of care **Intended use:** NICE **Prioritization process:**Indicator development will reflect priorities agreed with NHS England, Public Health England, the Department of Health and Social Care and the devolved administrations in Northern Ireland and Wales. Initial suggestions are based on publication of: new national policy, for example, the NHS Long Term Plan, new or updated NICE quality standards or guidance, new or updated reports of current national performance. Indicators may also be developed or assured for organizations that commission NICE to undertake specific pieces of indicator related work. Areas for indicator development are presented to the indicator advisory committee alongside relevant guidance recommendations and current practice data. The indicator advisory committee advises on progression to the development stages by examining current variation in practice, opportunities to improve clinical outcomes, early feasibility assessment and the content of evidence-based guidance. To utilize externally developed indicators and avoid system wide duplication of effort, the indicator advisory committee may also use the criteria outlined in appendix B to assess the validity of indicators developed by external organizations for inclusion on the NICE menu. Drafting indicator wording and specification is an iterative process	**Eligibility:** N/A **Nature of the measures:** Unclear : NICE indicators generally measure outcomes that reflect the quality of care or processes linked by evidence to improved outcomes. Process indicators are evidence-based and underpinned by NICE quality standards, NICE guidance or other sources of high-quality evidence. **Criteria definition:** Importance = The indicator reflects a specific priority area identified by NHS England or Public Health England; The indicator relates to an area where there is known variation in practice; The indicator will lead to a meaningful improvement in outcomes; The indicator addresses under or over-treatment. Evidence base = The indicator is derived from a high quality evidence base; The indicator aligns with the evidence base. Specification = The indicator has defined components necessary to construct the indicator, including numerator, denominator and exclusions; The indicator has a minimum population level. Feasibility = The indicator is repeatable; The indicator is measuring what it is designed to measure; The indicator uses existing data fields or the burden of additional data collection is acceptable. Acceptability = The indicator assesses performance that is attributable to or within the control of the audience; The results of the indicator can be used to improve practice. Risk = The indicator has an acceptable risk of unintended consequences **Compared to NHQDR:** Both criteria sets include importance, feasibility, and improvability. This criteria set includes: Evidence-based; The indicator has defined components necessary to construct the indicator, including numerator, denominator and exclusions; The indicator has a minimum population level; Acceptability; The indicator has an acceptable risk of unintended consequences, while the NHQDR set does not.	Importance Evidence base Specification Feasibility Acceptability Risk

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	undertaken primarily by NICE and the National Collaborating Centre for Indicator Development. All NICE indicators undergo testing to assess feasibility and acceptability. NICE asks for comments from stakeholders and respondents (including patient organisations and professional groups) on potential new indicators during a 4 week public consultation. They are asked to comment on: risk of unintended consequences, barriers to implementation, impact on equality groups. Indicator development may include a consideration of cost effectiveness when indicators are intended for inclusion within a pay-for-performance framework. The indicator advisory committee considers the results of indicator development (including the testing results, equality analysis and any cost-effectiveness analysis) alongside comments submitted during the public consultation. High-level assessment of resource impact is considered for all indicators in development. **Context:** N/A **Engagement:** Yes Stakeholders are involved in the development of NICE indicators, but specific details on how they are involved are not reported **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Unclear All NICE indicators undergo testing to assess feasibility and acceptability. The testing options available include, but are not limited to: desktop review to assess availability of existing data sources; quantitative data analysis of relevant and availabl		

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
NQF, 2002[128] US	**Setting:** Healthcare quality of care **Intended use:** NQF **Prioritization process:**One of the NQF's earliest initiatives was the appointment in December 1999 of a nine-member Strategic Framework Board (SFB) whose purpose was to (1) propose a national strategy for healthcare quality measurement and reporting; (2) articulate guiding principles and priorities for healthcare quality improvement, including the roles of key players; and (3) identify potential barriers to successful implementation of the recommended national strategy and possible solutions to those barriers. During its 18-month tenure, the SFB frequently briefed the NQF Board of Directors and members on its evolving views about a national framework for healthcare quality measurement and reporting, obtaining feedback on the ideas as they were developed. In October 2001, the SFB forwarded to the NQF a final Executive Summary of its proposed framework. These recommendations were carefully considered by NQF member organizations and the general public, and they were revised in response to the reviews. The recommendations were subsequently voted on and overwhelmingly approved by the NQF membership and in May 2002 by the NQF Board of Directors. **Context:** N/A **Engagement:** Yes This framework included 17 specific recommendations to be acted on by the NQF. These recommendations were carefully considered by NQF member organizations and the general public, and they were	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance, feasibility, improvability, and applicability to national priorities. The NQF criteria set also includes: help consumers select plans, providers, or treatments, while the NHQDR set does not.	Are linked directly to a national goal Have a clear and compelling use Do not impose undue burden on those who provide data Help consumers select plans, providers, or treatments Help providers improve the delivery of care

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	revised in response to the reviews. The recommendations were **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically		
NQF, 2024[129] NQF, 2007[146] US	**Setting:** Healthcare quality of care **Intended use:** NQF **Prioritization process:**Call for intent to submit measures; call for nominations (allows anyone to suggest a candidate for the committee that will oversee the project); call for standards (starts a 30-day period for developers to submit a measure or practice through online submission forms); steering committee review to put submitted measures to a four-part test to ensure they reflect sound science, will be useful to providers and patients, and will make a difference in improving quality; public comment solicits input from anyone who wishes to respond to a draft report that outlines the steering committee's assessment of measures for possible endorsement; member vote asks NQF members to review draft report and cast votes on endorsement; CSAC review marks the point at which NQF Consensus Standards Approval Committee deliberates on merits of measure and issues raised during review process and make recommendation to Board of Directors; board ratification; appeal opens a period when anyone can appeal the Board's decision. **Context:** It seems that this criteria has been used for measure endorsement by NQF.	**Eligibility:** N/A **Nature of the measures:** Structure : nursing care hours per patient day; adoption of medication e-prescribing,Process : cervical cancer screening,Outcome : BMI in adults >18 years of age,Patient experience : HCAHPS - patient experience with care survey for patients who have been in the hospital **Criteria definition:** Important to measure and report = to keep our focus on priority areas, where the evidence is highest that measurement can have a positive impact on healthcare quality Scientifically acceptable = so that the measure when implemented will produce consistent (reliable) and credible (valid) results about quality of care Usable and relevant = to ensure that intended users--consumers, purchasers, providers, and policy makers--can understand the results of the measure and are likely to find them useful for quality improvement and decision making Feasible to collect = with data that can be readily available for measurement and retrievable without undue burden **Compared to NHQDR:** Both criteria sets include importance, scientific soundness/acceptability, validity, reliability, usability, and feasibility. The NHQDR has other criteria that are not included in the NQF endorsement process.	Important to measure and report Scientifically acceptable Usable and relevant Feasible to collect

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Engagement: Yes convening panels and stakeholders, including consumer representatives, from across the healthcare arena to identify areas where new measures are especially needed. Develops consensus among stakeholders about which measures warrant endorsement as the "best **Evidence-based:** Empirically based **Defined population:** Unclear NQF addresses US population, but doesn't explicitly state the target population for endorsement process **Validity testing status:** Tested Part of the endorsement process includes a steering committee review, where they put submitted measures to a 4-part test to ensure they reflect sound science, will be useful to providers and patients, and will make a difference in improving quality.		
Pap, 2022[106] Australia	**Setting:** Australian prehospital care quality **Intended use:** N/A **Prioritization process:** A modified RAND/UCLA appropriateness method was conducted with a panel of Australian prehospital care experts from February to May 2019. The proposed QIs stemmed from a scoping review and were systematically prepared within a clinical and non-clinical classification system, and a structure/process/outcome and access/safety/effectiveness taxonomy. Rapid reviews were performed for each QI to produce evidence summaries for consideration by the panellists. QIs were deemed valid if the median score by the panel was 7–9 without disagreement. **Context:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure : The ambulance service has a policy that defines specific categories of patients for which receiving facilities are to be notified of the patient's arrival.,Process : A patient suspected of opioid overdose who is unconscious or has depressed respiration is administered naloxone (2 mg, intramuscular/intranasal/ intravenous), unless contraindicated.,Outcome : A responsive patient who is administered analgesic agent(s) does not require airway management or ventilatory support following the administration, unless anaesthesia is being induced. **Criteria definition:** Validity = panelists were asked to consider the summarized evidence as well as their own knowledge and experience to rate each indicator validity in the context of contemporary Australian prehospital care **Compared to NHQDR:** Both criteria sets include validity. The criteria for the Australian prehospital indicators includes only validity, as this study was part one of a three part process, where next phases will include testing indicators against criteria of acceptability, feasibility, and reliability.	Clarity Validity

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Engagement: Yes Australian prehospital care experts participated in modified RAND/UCLA appropriateness method. Rapid reviews were performed for each QI to produce evidence summaries for consideration by the panellists. **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication this has been tested empirically	Both frameworks include equity, safety, effectiveness, access, patient-centeredness, efficiency, timeliness, and continuity of care.	
Perera, 2007[107] New Zealand	**Setting:** Primary care performance **Intended use:** N/A **Prioritization process:**Literature review of published and grey literature on the development and use of performance indicators in health care. Interview with a range of key stakeholders from the New Zealand primary health care sector to gain a broad perspective on the role and potential impact of performance indicators on New Zealand primary health care. Design of framework by blending information gained from review of literature and interviews to create a functional tool that could be utilized in the New Zealand health care context and be applicable to other health systems around the world. Sieve tool was generated from the theoretical framework, and used for appraisal of ten clinical, four laboratory and three prescribing indicators that were to be implemented in the PHO Performance Management Program. Utilization of sieve tool involved collation and analysis of international and local evidence pertaining to each indicator, a literature search for each indicator to find evidence based with regard to best practice, cost effectiveness and use as an	**Eligibility:** N/A **Nature of the measures:** Structure : No example provided, but noted that this type of indicator is included,Process : Influenza vaccinations in the elderly,Outcome : Rates of adults with smoking status recorded **Criteria definition:** Definition and Purpose of indicator = clarity of definition, purpose of indicator, policy relevance Evidence based for Organization Performance = There is evidence (positive or negative) for use of this indicator in: performance measurement of an organization, audit and feedback at the level of the individual clinician, educational program without local audit data (e.g., impact of guidelines), other Evidence base = There is evidence (positive or negative) related to the clinical validity/health outcomes of this indicator from: meta analyze/systematic reviews, individual intervention studies, individual descriptive studies, consensus; Available evidence relates to: morbidity, mortality, cost of care Perspective from which the indicator is derived = cost effectiveness/cost containment, professional competence/accreditation, population health (i.e. is meaningful in terms of population health outcomes e.g., immunization), personal health, patient/consumer (e.g., waiting times), of local importance (country/regional specific), health inequalities Technical characteristics of indicator = The primary focus of this indicator within the health organization relates to: structure, process, outcome; the indicator has been demonstrated to be a valid measure of performance; the indicator has been demonstrated to be a reliable	Rationale for the choice of indicator: a. The stated purpose for the introduction of the indicator b. The relevance of the indicator to current policy c. Current best practice, which includes the importance of the indicator in relation to clinical validity/health outcomes d. Evidence relating to previous use of the indicator as a measure of quality in an organizational setting e. The perspective from which the indicator is derived Technical merits of the indicator: a. Key criteria highlighted in the published literature and interviews, which illustrate how well that indicator performs in practice Implementation issues: a. Key issues pertaining to data collection b. Key issues pertaining to data analysis

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	indictor of good performance or quality in a PHO. Once evidence review was completed for each indicator, members of research team applied it against each of the criteria int he tool. Combination of evidence and technical judgement was then required to make an assessment of the various components of the sieve tool for each indicator. A final summary statement of the overall assessment of each indicator was then provided using the combined text and categorical information available from the sieve tool. **Context:** N/A **Engagement:** Yes 14 interviews with stakeholders to determine the role, relevance, and applicability of performance indicators in primary health care, to identify potential indicators, and to understand the attitudes and challenges, and the constraints of and barriers to, **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Authors applied the tool to the assessment of a set of proposed national performance indicators for primary health care in New Zealand	measure of performance; change in the indicator is linked to health outcomes; change in the indicator is attributable to primary care intervention; the indicator lends itself to a target setting process; the indicator is able to detect differences between primary care organizations; the indicator allows clear assessment of change in performance (better or worse); there is available risk adjustment for background demographics, access barriers; the indicator is able to reflect cultural values; this indicator is best interpreted in conjunction with the collection of local experiences and knowledge (e.g., presence of local anti-immunization lobby); the indicator is not subject to confounding by factors outside the control of the provider e.g., population characteristics, resources; it is a stand-alone indicator (i.e. it can be analyzed in isolation from other indicators) Data collection = There is clarity about the unit of analysis (e.g., relates to individual clinician, aggregates of clinician, nurse, doctor, team or organization; the sample/population is well defined e.g., women, men, etc.; exclusions are well defined; data collection specifications are well defined; required data elements for indicator can be obtained from existing data sources; required data elements for the indicator can be gathered during routine practice activities; existing IT software is sufficient for data collection; existing IT software is sufficient for data collation Data analysis = There is a defined measurement/scoring system for collected data; precision/accuracy of data collection can be verified; reports can be easily generated from the collated data for feedback **Compared to NHQDR:** Both criteria sets include reliability, validity, importance, scientific soundness, feasibility, usability, type of measure used, applicably to general population, at least some data, improvability, sound measure available, applicability to national priorities, population equity, and geographic and health systems equity. The New Zealand criteria set also includes: The stated purpose for the introduction of the indicator; The perspective from which the indicator is derived; and numerous others listed in figure 2 of the paper, that the NHQDR does not.	
Reeve, 2015[110] Austral ia	**Setting:** Primary health care quality of care **Intended use:** N/A **Prioritization process:**The evaluation framework was presented and discussed	**Eligibility:** N/A **Nature of the measures:** Structure : Availability of community health care clinics and emergency services in communities by location of health services and hours they are staffed,Process : Number of	Relevant Workable

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	at a series of workshops with key stakeholders, including health service providers, policymakers and community members for input and modification. The aim of these workshops was to provide a forum for feedback, agreement was reached through discussion and consensus achieved by the group around which indicators were relevant and workable based on their experience. **Context:** N/A **Engagement:** Yes Local information was collected through in-depth interviews conducted with key stake-holders and focus groups. Five stake-holder interviews and four focus groups were completed. Focus groups comprised health service providers (ten people), health govern **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication this has been tested empirically	emergency department visits per year,Outcome : Annual mortality rate for population **Criteria definition:** Relevant = relevant to the study's context Workable = achievable based on current data sets based on workgroup's experience **Compared to NHQDR:** Both criteria sets include importance/relevance and feasibility/achievable based on current data sets. The NHQDR has many other criteria not included in this study. Both frameworks include equity, access, effectiveness, efficiency, continuity of care, and health systems infrastructure capabilities.	
Reiter, 2011[11] Germany	**Setting:** Hospital quality of care **Intended use:** Institute for Quality and Patient Safety (BQS Institute) **Prioritization process**:Committee assessing indicators. For each criterion a core statement was provided and the expert group determined the degree to which the criterion applied to the indicator under assessment. For example, the core statement for the criterion "benefit" was "The use of this quality indicator can positively influence the quality of care". The expert group rated the indicator using the following range of descriptors: "does not apply", "rather does not apply", "rather applies", "applies" and "abstention". The results of the first	**Eligibility:** N/A **Nature of the measures:** Outcome : Perioperative stroke or death, postoperative mortality,Unclear : The full list of measures are not reported. **Criteria definition:** Relevance = Importance of the quality characteristic captured with the quality indicator for patients and the health care system*; Benefit*; Consideration of potential risks / side effects* Scientific soundness = Indicator evidence*; Clarity of the definitions (of the indicator and its application)* Reliability*; Ability of statistical differentiation*; Risk adjustment*; Sensitivity; Specificity; Validity* Feasibility = Understandability and interpretability for patients and the interested public* Understandability for physicians and nurses; Indicator expression can be influenced by providers*; Data availability; Data collection effort; Barriers for implementation	Relevance Scientific soundness Feasibility

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	assessment round were collected and responses counted. If a complete count of votes and consen- sus was reached, the evaluation of the quality indicator for the respective crite- rion was finished. In all other cases ratio- nale for ratings was exchanged among members. Consensus was not forced. Following the discussion, the members rated the indicator in a second undis- closed and final assessment round. **Context:** To assess quality indicators **Engagement:** Yes Multi-disciplinary groups for every clinical condition (e.g., obstetrics, pacemaker) consisting of 11 to 15 members with specific expertise: two patient representatives, two physicians representing German Hospital Association, tow physicians representing **Evidence-based:** No **Defined population:** Yes (framework target described in detail) hospital **Validity testing status:** Not tested	considered; Correctness of data can be verified*; Completeness of data can be verified*; Complete count of data sets can be verified* **Compared to NHQDR:** The criteria Importance, Scientific soundness, Reliability, Validity, Feasibility were included in this study and the NHQDR. The three main categories in the QUALIFY instrument are relevance, scientific soundness, and feasibility, and specific criterion (e.g., importance, validity, reliability, and more) are filed under those three categories, while the 2010 NHQDR criteria don't have sub-criterion.	
Remin gton, 2015[11][2] US	**Setting:** County level population health **Intended use:** University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation **Prioritization process:** Not reported **Context:** To measure county level population health rankings **Engagement:** No Model suggested by University of Wisconsin Population Health Initiative with help of RWJF **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied in different context	**Eligibility:** N/A **Nature of the measures:** Structure : Access to care (e.g., mental health providers),Process : Diabetic screening, mammography screening,Outcome : Length of life, low birthweight **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include reliability, validity, usability, importance, improvability, linkable to established indicator sets, applicability to general population. The County Health Rankings criteria includes available at low or no cost, recently or regularly updated, feedback from a panel of technical experts, and fewer measures are better than more, while the NHQDR set does not. Both frameworks considers healthcare and access to care.	Reflect important aspects of population health that can be improved Availability and reliability of indicators at the county level throughout the nation Ability for conditions underlying a measure to be modified through community action Valid, reliable, recognized, and used by others Available at low or no cost Recently and regularly updated Feedback from a panel of technical experts Alignment with America's Health Rankings' indicators Fewer measures are better than more

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Rezap our, 2019[11 3] Iran	**Setting:** Primary health care quality of care **Intended use:** N/A **Prioritization process:**Comprehensive literature review of primary health care quality assessment frameworks, dimensions and quality indicators. A set of preliminary extracted QIs (698 QIs) was categorized by the research team using the information of the existing literature. In order to assess and select the final QIs, this collection was provided to the experts through holding panel meetings for the experts and also the Delphi method. For the initial evaluation of QIs and quality dimensions, 2 panel sessions were held with the participation of 8 experts. During these meetings, in addition to content analysis of the QIs, the relevance of the initial QIs to the local conditions of Iran, the coverage of current high-priority processes and their proportionality to the national PHC program were examined. Finally, an initial list was extracted for countrywide assessment. The countrywide assessment and prioritization of QIs was done through the Delphi method. The Delphi questionnaire/form was designed according to the comprehensive literature review and experts' comments. The Delphi questionnaire was designed in such a way that the experts could assign an independent score ranging from 1 to 5 to each of the QIs in three dimensions of importance, relevance and feasibility in the healthcare system of Iran. After collecting the data, the average scores assigned to the QIs were calculated in terms of all the three dimensions on a scale of 100. Determining the priority of	**Eligibility:** N/A **Nature of the measures:** Structure : % of catchment population who received at least one basic visit (listed as structure in paper),Process : % of patients with mental disorders that have had a follow-up visit in defined period according to national protocol,Outcome : % of pregnant women with first visit at the first trimester **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance, feasibility, improvability, and applicability to national priorities. The Iranian PHC criteria set includes maximum coverage of current primary health care processes, while the NHQDR set does not. Both frameworks include patient-centeredness, safety, access, equity, effectiveness, and efficiency.	Importance Relevance Feasibility Relevance to national primary health care programs Global and national priorities in primary health care Maximum coverage of current primary health care processes The possibility of interventions to improve the quality indicators

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	the QIs was carried out using the approach of the WHO EMRO office. Therefore, the QIs with a final mean score of more than 70 were identified as the first priority; those with a mean score of 40 to 70 were identified as second priority; and the QIs with a mean score of less than 40 were excluded from the final QAF. Core indicators were ones which should be measured in all the provinces in meso levels and non-core indicators were ones which measured to provide additional information according to characteristics of the settings. To develop a QAF for Iran. In the panel sessions, the selected QIs of the Delphi study were evaluated according to 4 criteria as follows: 1. Relevance to national PHC programs 2. Global and national priorities in PHC 3. Maximum coverage of current PHC processes 4. The possibility of interventions to improve the QIs **Context:** N/A **Engagement:** Yes The extracted quality dimensions and indicators for initial screening were reviewed and discussed in two panel meetings attended by the experts with regard to the current package of health system in Iran. Using Delphi method, the dimensions and Quality In **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that the model has been tested empirically		
Riehle, 2007[11][4]	**Setting:** Healthcare or hospital quality of care and performance **Intended use:** Joint Commission	**Eligibility:** N/A **Nature of the measures:** Structure : Staff turnover rate; understaffing as compared to organization's staffing plan,Process : Colorectal cancer: complete prep colon exam prior to colon	Target improvement in the health of populations Precisely defined and specified Reliable

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Johnson, 2016[153]; McGreevey, 1997[140] US	**Prioritization process**:Initial measure development requires significant preliminary work, including a review of the literature to evaluate the evidence base and identify existing measures in a particular topical area. The findings from this review are summarized and serve as the basis of a measurement framework, which is used throughout the development process. The first formal step in the process is the empanelling of a group of experts with balance as a key focus. After the panel has convened, The Joint Commission issues a "call for measures" to solicit measures from all known measure developers. The measures received are vetted by staff, and evaluated against The Joint Commission's attributes of core performance measures and associated evaluation criteria. **Context:** These criteria has been used to develop measures of hospital quality and performance. **Engagement:** Yes Panel convenes, and then Joint Commission issues a "call for measures" to solicit measures from all known measure developers **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Unclear These criteria have been used by Joint Commission, but the article doesn't clear any type of validity test having been done	resection,Outcome : Postoperative infections; pressure ulcer prevalence,Patient experience : Patient/family complaints/satisfaction **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include reliability, validity, usability, applicability to the general population, at least some data, improvability, and sound measure available. The Joint Commission criteria set includes: Precisely defined and specified; Risk-adjusted or stratified; Under provider control; Are useful in the accreditation process, while the NHQDR does not.	Valid Easily interpreted by users Risk-adjusted or stratified Under provider control Have publicly available measure constructs Useful in the accreditation process Rely on accessible data and low-cost data collection efforts In addition:[140] Clinically important Relevant across organizations Feasibility
Rohe, 1999[115] US	**Setting:** Hospital quality of care **Intended use:** N/A **Prioritization process**:The first step is to apply brainstorming techniques to create a set of definable quality measures. The manager and line staff are best suited to develop this list. The session can be set	**Eligibility:** N/A **Nature of the measures:** Structure : Nursing aptitude,Outcome : Patient falls,Patient experience : Patient satisfaction **Criteria definition:** N/A **Compared to NHQDR:**	1. Eliminate the ridiculous ideas 2. Toss out redundant criteria 3. Disregard immeasurable criteria 4. Importance

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	up like a contest. The facilitator and the line staff and manager take turns generating possible quality measures. During this process, no judgement is exercised in the relative impact of the measure or how to quantify the measure. The list germinated usually ranges from the ridiculous to the realistic and from the measurable to the immeasurable. After brainstorming exhausts all potential measurable factors, a review of the ideas generated is made to: 1. Eliminate the ridiculous ideas 2. Toss out redundant criteria and 3. Disregard immeasurable criteria. The list of criteria remaining are then prioritized into three categories. An A is listed by those criteria that are life-threatening or crucial to the department's mission. B is listed beside those that are major concerns for the department's operation or well-being of the patient. However, a mistake in these criteria could be rectified without harm to the patient. Finally, a C is placed next to those items that are nuisance or moderate concerns to the operation. As the criteria are developed, the manager and line staff define, where applicable, the range of measures that are acceptable and unacceptable. This process takes a percent weight of a criterion and distributes it between what is accepted and what is not. Next, another list is prepared with the A items on top, B items in the middle, and C items at the end. Manager now applies a percentage of importance to each category with the total being 100%. This is the relative importance that each category has with respect to each other. The manager and line staff are then asked to weight the relative importance of each criterion within	Both criteria sets include importance and "sound measure available". The criteria in this article includes Eliminate the ridiculous ideas; Toss out redundant criteria, while the NHQDR does not.	

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	each category so that the total of the category comes out to 100%. **Context:** Has been used in coronary care unit. Also has been used in getting doctors with diverse opinions to create a "physician rounding factor" which gauges a hospital's efficiency in helping them round on the units. **Engagement:** No Suggested by author **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Tested Has been applied in different contexts		
Rushforth, 2015[116] UK	**Setting:** Quality of care for primary care **Intended use:** N/A **Prioritization process:**Initial screening: identified candidate recommendations and indicators from NICE clinical guidelines and quality standards, and Quality and Outcomes Framework clinical domain indicators through a systematic screening and abstraction process Online shortlisting by consensus panel: convened a consensus panel comprising 11 members; conducted an online rating process whereby panelists rated each recommendation from the previous step according to three criteria: burden of illness, potential for significant patient benefit, and scope for improvement upon current levels of adherence Face-to-face consensus panel meeting: used a modified RAND process; panelists independently completed an additional online survey and rated the recommendations resulting from the previous step on a 9-point Likert scale according to three criteria: feasibility of measuring adherence, extent to which	**Eligibility:** N/A **Nature of the measures:** Process : 9 annual processes of care, i.e., measurement of BP, lipids, renal function, urine albumin-creatinine ratio, glycemic control, BMI, smoking status, plus foot and eye checks,Outcome : % of patients with diabetes in whom the last BP is <=140/80 mmHg **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance, improvability, and feasibility. This criteria set also includes "the likelihood of cost savings without patient harm," while the NHQDR criteria set does not.	2nd step: Burden of illness (e.g., prevalence, severity, costs) Potential for significant patient benefit (e.g., longevity, quality of life, safety of care) Scope for improvement upon current levels of adherence (e.g., from perceived current low levels of high variations) 3rd step: Feasibility of measuring adherence (e.g. from clinical data routinely collected for QOF) Extent to which following a recommendation is directly within the control of individual practice teams or professionals The likelihood of cost savings without patient harm

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	following a recommendation is directly within the control of individual practice teams or professionals, and the likelihood of cost savings without patient harm Informal sense-checking: identified a convenience sample of 4 family physician commissioning leads and 6 academic family physicians to review the full ranked list of recommendations from the 2nd step, select between 5-10 recommendations that they considered would best meet the authors' aims and highlight any they considered problematic to target; authors then collated their selections and written comments; the research team drew upon this further feedback in discussions to finalize the selected high impact recommendations **Context:** N/A **Engagement:** Yes Face to face consensus panel meeting using modified RAND process **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Field tested the QIs using remotely extracted, anonymized patient records from 89 randomly sampled primary care practices in the Yorkshire region of England		
Schange, 2021[117] Germany	**Setting:** Healthcare quality of care **Intended use:** N/A **Prioritization process:**Systematic review **Context:** N/A, has not been used to develop measures yet **Engagement:** No Authors conducted a systematic review of criteria in the	**Eligibility:** N/A **Nature of the measures:** Structure : noted in paper but no example provided,Process : noted in paper but no example provided,Outcome : noted in paper but no example provided **Criteria definition:** Content validity - content coverage = degree to which the set covers the content domains	Content validity Cost of measurement Avoid redundancy Size Prioritization

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	literature. Stakeholders were involved in some of the studies found. **Evidence-based:** Empirically based **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication the specific list of criteria from this systematic review has been tested together	Content validity - breadth = degree to which the set covers all relevant content domains Content validity - depth = degree to which the set covers a specific content domains (and its subdomains) properly Content validity - not specified = degree of content coverage, no specification concerning breadth or depth Content validity - proportional representation = number of indicators in each domain matches the importance of the respective domain in the construct Content validity - contamination = the set does not contain irrelevant indicators Cost of measurement = costs associated with measuring the set as a whole (related to, e.g. data collection, analysis and reporting) Avoid redundancy = additional indicators do not duplicate existing indicators Size = the set consists of an appropriate/a specific number of indicators Prioritization = the set includes the 'most important' or 'essential' indicators for the purpose of assessment Consider assessment purpose = the set is developed with the assessment purpose in mind Develop/use conceptual framework = the set is developed based on a conceptual framework Stakeholder involvement = stakeholder groups are involved in the development process Provider involvement = provider groups are involved in the development process Patient involvement = patient groups are involved in the development process Stakeholder involvement - other = other groups (e.g. researchers and purchasers) are involved in the development process Transparency of development process = methods and limitations are transparently presented	

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
		Compared to NHQDR: Both sets of criteria include importance and validity. The criteria specified in this review include: Cost of measurement; Additional indicators do not duplicate existing indicators; the set consists of an appropriate/specified number of indicators; Consider assessment purpose; Developed based on a conceptual framework; Stakeholder groups are involved in the development process; and Transparency of development process, while the NHQDR does not. The criteria validity was also broken down into several categories content coverage (breadth, depth, not specified), proportional representation, and contamination, while the NHQDR does not.	
Schoen, 2006[118] US	**Setting:** Health system performance **Intended use:** Commonwealth Fund **Prioritization process:** Within each dimension, the Commission identified priority areas and sentinel, or "whole-system," indicators where improvement would make a positive difference for the nation and where data currently exist to track and compare performance over time. The Commission selected key indicators for each dimension of performance that would enable comparisons of U.S. average performance levels to benchmarks drawn from national and international experiences. **Context:** N/A **Engagement:** No Model suggested by authors **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Structure : Care coordination at hospital discharge,Process : Adults received recommended screening and preventive care,Outcome : Mortality amenable to health care,Patient experience : Doctor-patient communication: always listened, explained, showed respect, spent enough time **Criteria definition:** N/A **Compared to NHQDR:** There don't appear to be clear similarities between the two criteria sets, though both do address health system delivery/quality of care. The Commonwealth Fund process includes: Within each dimension, the Commission identified priority areas and sentinel, or "whole-system," indicators where improvement would make a positive difference for the nation and where data currently exist to track and compare performance over time; and The Commission selected key indicators for each dimension of performance that would enable comparisons of U.S. average performance levels to benchmarks drawn from national and international experiences, while the NHQDR does not. Both frameworks include equity, safety, access, patient-centeredness, efficiency, timeliness, care coordination, and types of care.	Making a positive difference for the nation Data currently exists to track and compare performance over time
Schoenmakers,	**Setting:** Community pharmacy quality of care **Intended use:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure : Professional development of pharmacy staff; Structures available for assessment of suppliers,Process : Percentage of patients chronically using loop	Content validity Selection bias Measurement bias Statistical reliability

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
2015[119] Netherlands	**Prioritization process**:Between April and May 2012, all 1,987 Dutch community pharmacies were requested to complete an online question- naire about the QIs. This questionnaire contained 1 or more questions for each QI with options for dichotomous or categori- cal answers or fields to provide numerators and denominators for numerical QIs. Per QI, community pharmacists could add comments and information in a free text field in the online questionnaires. During data collection, a help desk was avail- able for questions. Results from all community pharmacy questionnaires were used to generate benchmark reports. The benchmark results, response rates, comments, and questions were accessible to the expert panel and thus could serve as information from a practice test. For dichotomous QIs, the benchmark reports provided insight into discriminatory power and ceiling effects. **Context:** N/A **Engagement:** Yes An expert panel was formed, which consisted of 6 pharmacists who had participated in the data collection--5 practicing community pharmacists and a pharmacist/epidemiologist, who served as project leader in the development and data collection process. **Evidence-based:** Unclear **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested 1,987 Dutch community pharmacies were requested to complete an online question- naire about the QIs. This questionnaire contained 1 or more questions for each QI with options for dichotomous or categori-	diuretics and RAS inhibitors who are dispensed NSAIDs; management of interactions between oral anticoagulants and co-trimoxazole; percentage of benzodiazepine users who received verbal information about dependency with a follow-up prescription of benzodiazepines,Outcome : Number of patients who concurrently use oral anticoagulants and co-trimoxazole,Patient experience : Year of most recent evaluation of patients' experiences; number of registered complaints made by patients **Criteria definition:** Content validity = the degree to which the QI directly reflects the performance of the community pharmacist or pharmacy team Selection bias = the degree to which differences between populations of pharmacies with regard to age, drug use, morbidity, or social economic status could have influenced the results of a QI Measurement bias = differences in data collection by community pharmacies that were likely to bias comparisons between QI results Statistical reliability = detect differences between community pharmacies with sufficient statistical confidence, results from numerical QIs were subjected to a statistical test **Compared to NHQDR:** Both criteria include validity and reliability. This criteria set was used to select quality indicators for community pharmacies, while the NHQDR criteria set was used for healthcare quality indicators. This criteria set includes selection bias and measurement bias, while the NHQDR set does not. Both frameworks include continuity of care, either resources or infrastructures capabilities, safety (clinical risk management), and types of care (pharmacy).	

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	cal answers or fields to provide numerators and den		
Simou, 2014[120] Greece	**Setting:** Public Greek National Health System hospitals **Intended use:** N/A **Prioritization process:**A literature review was conducted in the MEDLINE database to identify articles referring to international and national hospital quality assessment projects, together with an online search for relevant projects. Studies were included if they were published in English, from 1980 to 2010. A consensus panel took place afterwards with 40 experts in the field and tele-voting procedure. **Context:** N/A **Engagement:** Yes Consensus meeting to deliver assistance in successfully selecting useful standards for Greek public hospitals **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this model has been tested empirically	**Eligibility:** N/A **Nature of the measures:** Structure : Clearly defined responsibilities in staff; continuous education for health professionals,Process : Exams ordered at the ER per patient; usage of laboratory exams; laparoscopic/open surgery rate,Outcome : Inpatient mortality from stroke pneumonia, hip fracture, etc.,Patient experience : Patient feedback management; satisfaction from hospital environment (cleanliness, quietness, privacy) **Criteria definition:** Importance = impact on health status, policy relevance, susceptibility to being influenced by the public health system performance Feasibility = data availability, reporting burden **Compared to NHQDR:** Both criteria sets includes importance and feasibility. There are many criteria in the NHQDR set that are not in the set for Greek public hospitals. Both frameworks include effectiveness, safety, patient centeredness, efficiency, timeliness, and infrastructure resources/capabilities.	Importance Feasibility
Smith, 2010[121] UK	**Setting:** Healthcare performance **Intended use:** N/A **Prioritization process:**Development of a clear conceptual framework and a clear vision of the purpose of the performance measurement system Design of data collection mechanisms Information governance Development of analytical devices and capacity to help understand the data	**Eligibility:** N/A **Nature of the measures:** Structure : Labor productivity,Process : Frequency of blood pressure measurement,Outcome : Specific post-operative readmission and mortality rates,Patient experience : Patient satisfaction measures **Criteria definition:** Development of indicators: Face/content validity = the extent to which the indicators accurately measures what it purports to measure Reproducibility = the extent to which the indicator would be the same if the method by which it was produced was repeated	Development of indicators: Face/content validity Reproducibility Application of indicators: Acceptability Feasibility Reliability Sensitivity to change Predictive validity

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ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Development of appropriate data aggregation and presentational methods Design of incentives to act on performance measures Proper evaluation of performance-measurement instruments Managing the political process **Context:** N/A **Engagement:** No **Evidence-based:** No **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication that this has been tested empirically	Application of indicators: Acceptability = the extent to which the indicator is acceptable to those being assessed and those undertaking the assessment Feasibility = the extent to which valid, reliable and consistent data are available for collection Reliability = the extent to which there is minimal measurement error or the extent to which findings are reproducible should they be collected again by another organization Sensitivity to change = the extent to which the indicator has the ability to detect changes in the unit of measurement Predictive validity = the extent to which the indicator has the ability to accurately predict **Compared to NHQDR:** Both criteria sets include validity, reliability, and feasibility. The criteria in this study includes acceptability and sensitivity to change, while the NHQDR does not. Both frameworks include equity, access, timeliness, and effectiveness (population health and health outcomes in this framework).	
Stelfox, 2013[122] Canada	**Setting:** Healthcare quality of care **Intended use:** N/A **Prioritization process:** Research synthesis (identify quality indicators in literature); environmental scan of quality indicator practices (identify QIs in clinical practice); quality indicator development using consensus methodologies (select most promising QIs; develop new QIs); quality of care benchmarks: test QI properties, map quality of care, impact analysis, and long term outcomes **Context:** N/A **Engagement:** Unclear Article discusses selecting an expert panel as part of the process for QI development and evaluation	**Eligibility:** N/A **Nature of the measures:** Unclear : Not reported **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance, feasibility, usability, reliability, and validity. This criteria set also includes 'appropriate risk adjustment' and 'results easily interpreted', while the NHQDR criteria does not.	Targets important improvements Precisely defined and specified Reliable Valid Appropriate risk adjustment Reasonable cost data collection effort Results easily interpreted

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Evidence-based: Unclear **Defined population:** No (target unclear) **Validity testing status:** Not tested No indication that this has been tested empirically		
Sutcliffe, 2012[12][5] UK	**Setting:** Healthcare quality of care **Intended use:** NICE **Prioritization process:** Topic suggested facility and collation of information; prioritization of evidence-based recommendations by QOF Advisory Committee; indicator development, piloting and consultation; review by QOF Advisory Committee and publication; changes to QOF indicators negotiated using the NICE menu **Context:** N/A **Engagement:** Yes Stakeholder organizations and individuals can suggest clinical and public health topics for consideration for potential QOF indicator development; NICE consults with stakeholders on piloted indicators to allow them to comment on whether there are any barr **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested applied to a different context	**Eligibility:** N/A **Nature of the measures:** Process : statin use in people with hypertension at high risk of CVD,Outcome : obesity weight management programs **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance, feasibility, improvability, and applicability to national priorities.	By topic/disease condition: Relevance to primary care: prevalence and management Disease severity Potential to reduce health inequalities NHS priority area and timeliness By each clinical guideline recommendation for topic: Technical feasibility Clinical effectiveness Cost-effectiveness Likely change in current practice if implemented
ten Asbroek, 2004[12][6] Arah, 2003[25]	**Setting:** Dutch health system performance **Intended use:** Dutch Ministry of Health **Prioritization process:** Literature review, focused analysis of the policy and management roles of the Dutch MoH in relation to national stakeholders, analysis of existing information infrastructure for	**Eligibility:** N/A **Nature of the measures:** Structure : Indicator areas include diffusion of new technologies, human resources availability, vacancies, and staff satisfaction, etc.,Unclear : There are four indicator areas, including 'Consumer Perspective' (effectiveness, patient safety, and patient centeredness), but it's not clear if that falls into "Outcome (patient health)" or "Patient experience (satisfaction)" or both.	Indicator areas relevant for policy and management decisions in the specific Dutch context Complete set of indicator areas must be applicable to the entire Dutch health system

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Netherlands	public health and health care. Interactive process was formed by multidisciplinary academic research group, MoH strategic coordination group, and intradepartmental project group. The choices for the model and the indicator areas—made in the meetings between the three groups—were the result of decision making through a consensus approach after discussing strategic goals of the health system, information needs of policy makers at the MoH, and studying existing theory and international experiences with national performance indicator frameworks. **Context:** N/A **Engagement:** Yes Multidisciplinary academic research group at the Ministry of Health, a strategic coordination group, and an intradepartmental project group chaired by a director general of the MoH. The choices for the model and the indicator areas--made in meetings betwe **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically	**Criteria definition:** N/A **Compared to NHQDR:** Both sets include importance or "relevance". The Dutch criteria set includes "the complete set of indicator areas must be applicable to the entire Dutch health system", while the NHQDR doesn't have a criteria equivalent to that. The Dutch criteria set also appears to be for selecting indicator areas more broadly, while the NHQDR is meant to select indicators/measures itself. Both frameworks include equity, safety, effectiveness, access, efficiency, patient-centeredness, continuity of care, and health systems infrastructure capabilities. Both frameworks addresses healthcare/health system delivery.	
Valentine, 2008[13][4] Multiple countries	**Setting:** Non-clinical quality of care **Intended use:** N/A **Prioritization process:** After field testing (n=811 in eight countries and with 191 cognitive interviews), the importance question was developed for the responsiveness module in the MCS Study. It asked survey respondents to identify the most important domain, and the least important domain e in both cases, from a close-ended list of eight domains. The questions took on average	**Eligibility:** Non-clinical quality of care criteria **Nature of the measures:** Structure : Having enough space, seating and fresh air in the waiting room, having a clean facility,Process : Short waiting times for appointments and consultations, and getting tests done quickly,Patient experience : Being shown respect **Criteria definition:** N/A **Compared to NHQDR:** Both criteria sets include importance. The criteria by the WHO only includes importance, while the NHQDR has many other criteria.	Importance

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	5 min to administer and formed one of three parts to the responsiveness module. Other parts covered user ''experiences'', termed ''performance questions'' (49 items) and one on within-domain standards (termed the ''expectations questions'') (14 items) (see http://www.who.int/responsiveness/surveys/en/). **Context:** N/A **Engagement:** No Suggested by authors, using survey responses from population survey **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) Non-clinical quality of care for healthcare in 41 countries **Validity testing status:** Not tested No indication that this has been tested empirically	Both frameworks addresses healthcare quality, and includes access, timeliness, and health systems infrastructure capabilities.	
van den Berg, 2014[135] Delnoij, 2002; Westert, 2006; RIVM: De Zorgbalans, 2013 [http://bit.ly/1hYwvcH]	**Setting:** Dutch health care performance **Intended use:** Dutch Ministry of Health **Prioritization process:**The selection of the indicators was a result from ba-lancing the top-down approach with the bottom-up approach. From the top the health care system's objectives determine the indicator domains and relevant indicators to be used, while at the bottom the data sources and scientific state of the art determine the data availability and reliability to populate indicators. Therefore, the final selection of indicators is often a compromise between the conceptual relevance and the practical possibilities. **Context:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure : Uptake of preventive interventions for depression; percentage of schools that applied for the project 'The healthy school and drugs',Process : Participation rates of cancer screening,Outcome : Infant mortality **Criteria definition:** Quality of care = effectiveness, safety, responsiveness Accessibility = N/A Affordability = costs **Compared to NHQDR:** There were no similarities in the criteria between the two sets. The criteria used in the Dutch Health Care Performance Report included quality (effectiveness, safety, responsiveness), accessibility, and affordability, while the NHQDR criteria set does not. Both frameworks include equity as cross-cutting dimension, and the components safety, effectiveness, access, efficiency, and types of care.	Quality of care Accessibility Affordability

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
Netherlands	**Engagement:** Yes The choice for specific indicators resulted from a dialogue between researchers and policy makers. **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this current version of the criteria has been used (this report is updated every few years)		
Veillard, 2004[138] Multiple countries	**Setting:** Hospital performance **Intended use:** WHO Regional Office for Europe **Prioritization process:**The pre-selection was based on evidence in the literature, results of the survey in participating countries and expert judgement. Discussions took place at the third and fourth workshops. During the third workshop, four working groups composed of international experts (see appendix) in the different dimensions selected (clinical effectiveness and patient safety, staff orientation and staff safety, efficiency and patient centeredness, responsive governance and environmental safety) were asked to select indicators using a modified nominal group technique. They first scored them individually on a scale from 1 to 10 according to importance, validity and burden of data collection. Individual scores were reported to the group and discussed. Then indicators were allocated to a "core" or "tailored" baskets or excluded from the framework. During the fourth workshop, the list of indicators was reviewed to guarantee the content validity of the set of indicators as a whole. **Context:** N/A	**Eligibility:** N/A **Nature of the measures:** Structure : Bed occupancy rate,Process : Evaluation protocol for geriatric patients,Outcome : Percent of patients admitted on day of surgery for selected tracers **Criteria definition:** Evidence (of validity) and usefulness = When no or little evidence is available to support the indicator but that the indicator is considered useful and is used by many hospitals or included in many systems, it has strong face validity. It was agreed that, unless there is clear evidence to the contrary, it is acceptable to recommend measures that are based on usefulness rather than hard scientific evidence. Content validity of the set as a whole = N/A Challenges with data collection and operational definitions (reliability) = Ultimately the reliability of hospital performance indicators rests upon the quality of data from a variety of sources. A conclusion was that indicators (e.g. complications) should not be excluded merely because they require regularly missing or inaccurate data. On the contrary, they should be used as an opportunity to identify and respond to a need for education and improvement leading to more effective information systems. **Compared to NHQDR:** Both criteria sets include validity and reliability. This criteria set includes usefulness together with validity, while the NHQDR does not necessarily do so. This set also includes the criterion, content validity of the set as a whole, while the NHQDR does not. Both frameworks healthcare performance, and includes effectiveness, efficiency, safety, and patient-centeredness.	Evidence (of validity) and usefulness Content validity of the set as a whole Challenges with data collection and operational definitions (reliability)

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Engagement: Yes Workshops with stakeholders will be held to develop a set of indicators **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that this has been tested empirically		
Veillard, 2005[136] Multiple countries	**Setting:** Hospital quality of care **Intended use:** WHO **Prioritization process:** Criteria for indicator selection, as described in Table 3, were agreed on, through consensus among the experts. Specifically, four working groups were asked to score each individual indicator, using a nominal group technique, and to rank them on a scale from 1 to 10 according to importance, relevance and usefulness, reliability and validity, and burden of data collection. Criteria for indicator selection focused not only on the selection of individual indicators but also on the characteristics of the set of indicators as a whole. The final sets of indicators were obtained through the following steps: 1. Current national/regional performance assessment systems and their field applications were screened to establish a preliminary comprehensive list of 100 potential indicators. Experts scrutinized the list and proposed some refinements (dropping and adding some indicators); 2. Dimensions or subdimensions that were not properly covered were identified, and literature had to be further reviewed to identify indicators covering properly these areas. 3. An extensive review of the literature was carried out, evidence was	**Eligibility:** N/A **Nature of the measures:** Structure : Expenditures on health promotion activities; Absenteeism: short- term absenteeism,Process : Caesarean section delivery,Outcome : Mortality for selected tracer conditions and procedures,Patient experience : Average score on overall perception/ satisfaction items in patient surveys **Criteria definition:** Face validity = Is the indicator set acceptable as such by its potential users? Content validity = Are all the dimensions covered properly? Construct validity = How do indicators relate to each other? Importance and relevance = Does the indicator reflect aspects of functioning that matter to users and are relevant in current healthcare context? Potential for use (and abuse) and sensitivity to implementation = Are hospitals able to act upon this indicator if it reveals a problem? Reliability = Is there demonstrated reliability (reproducibility) of data? Face validity = Is there a consensus among users and experts that this measure is related to the dimension (or sub dimension) it is supposed to assess? Content validity = Does the measure relate to the sub dimension of performance it is supposed to assess? Contextual validity = Is the indicator related valid in different contexts?	Set of Indicators: 1. Face validity 2. Content validity 3. Construct validity Indicators: 1. Potential for use (and abuse) and sensitivity to implementation Measurement tools: 1. Reliability 2. Face validity 3. Content validity 4. Contextual validity 5. Construct validity 6. Burden of data collection

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	collected for each of 100 pre-selected indicators on the rationale for use, prevalence, validity and reliability, current scope of use, suggested and demonstrated relationship with other performance indica- tors, and on potential exogenous factors. **Context:** N/A **Engagement:** Yes series of four workshops gathering experts representing most valuable experiences on hospital performance assessment worldwide to provide input on PATH project and framework **Evidence-based:** Empirically based **Defined population:** Yes (framework target described in detail) **Validity testing status:** Not tested No indication that the model has been tested empirically	Construct validity = Is this indicator related to other indicators measuring the same sub dimension of hospital performance? Burden of data collection = Are data available and easy to access? **Compared to NHQDR:** Both criteria sets include validity, reliability, importance, usability, and data availability. The PATH criteria describes various types of validity as separate criteria, while the NHQDR set does not. Both frameworks include safety, patient-centeredness, effectiveness, and efficiency.	
Veillard, 2017[137] Multiple countries	**Setting:** Primary health care in low- and middle-income countries **Intended use:** No specific agency specified, but mention of national decision makers and global stakeholders (low- and middle-income countries) **Prioritization process:**The Primary Health Care Performance Initiative team developed the conceptual framework through literature reviews and consultations with an advisory committee of international experts. Authors generated 2 sets of performance indicators selected from a literature review of relevant indicators, cross-referenced against indicators available from international sources, and evaluated through 2 separate modified Delphi processes, consisting of online surveys	**Eligibility:** Primary health care performance in low- and middle-income countries **Nature of the measures:** Structure : Availability of essential drugs, vaccines; facilities with clean water, electricity, and sanitation,Process : Cancer screening rate,Outcome : Mortality rates,Patient experience : System for eliciting and reviewing client opinion; presence of client feedback system **Criteria definition:** 1. Relevance and importance = the indicator reflects important aspects of primary health care system performance 2. Reliability = the indicator produces consistent results 3. Validity = the indicator is an accurate reflection of the dimension of primary health care systems performance that it is intended to assess 4. Actionability = the indicator is useful for primary health care system performance improvement purposes 5. Feasibility = N/A **Compared to NHQDR:**	Criteria rated to select Vital Signs Indicators: 1. Relevance and importance 2. Reliability 3. Validity 4. Actionability Criteria rated to select Diagnostic Indicators: 1. Relevance 2. Validity 3. Actionability 4. Reliability 5. Feasibility

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ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	and in-person facilitated discussions with experts. **Context:** N/A **Engagement:** Yes Online surveys and in-person facilitated discussions with experts **Evidence-based:** No **Defined population:** Yes (framework target described in detail) **Validity testing status:** Tested Applied to different context	Both criteria sets include importance, reliability, validity, improvability/actionability, and feasibility. There are many criteria in the NHQDR set that are not included in the Primary Health Care Performance Initiative set. Both frameworks includes access, timeliness, safety, care coordination, person/patient centeredness, efficiency, and equity.	
Wollersheim, 2007[139] Netherlands	**Setting:** Healthcare quality of care **Intended use:** N/A **Prioritization process:**I. Selection of relevant patient group or care process. Criteria: 1. Experience with care problems (variation, suboptimal care, lack of safety, complaints, costs, long waiting and process times) 2. Important to the purpose of the department, care institution, or scientific association; or of political or moral importance 3. High volume 4. Enough evidence available II. literature search for indicators already developed or data about optimal care available (preferably recent evidence-based guidelines) III. Composition of a balanced consensus group and application of a structured development procedure 1. Specification. Extraction of concrete recommendations from evidence-based guidelines 2. Prioritising. Selection by an expert panel on the basis of relevance for health	**Eligibility:** **Nature of the measures:** Structure : For patients with head or neck tumor: Time to treatment (<30 days); admission time (<24 hours),Process : For patients with diabetes mellitus: Annual foot inspection carried out,Outcome : For patients with diabetes mellitus: Achieved an HbA1c of <7%,Patient experience : For patients with head or neck tumor: Psychosocial support **Criteria definition:** Relevancy = relevant to important aspects (effectiveness, safety, and efficiency) and dimensions (professional, organizational, and patient oriented) of quality of care Validity = strong correlation with the current quality of care; valid on the basis of good scientific proof and experience Reliability = low inter- and intra-observer variation; available and reliable data sources; statistically reliable, i.e., reported as an average or median with confidence intervals and valid for comparison, i.e., corrected for case mix and sociodemographic variables Feasibility = easily available; applicable to quality improvement, i.e., easy to build in improvement initiatives; sensitive to improvement in time; useful to base decisions on (caregivers, patients, regulating agencies); applying to those who should use them **Compared to NHQDR:** Both criteria sets include importance, validity, reliability, and feasibility. The NHQDR criteria has additional criteria that are not included in this criteria set.	Relevancy Validity Reliability Feasibility

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	benefit, efficiency, measurability, and improvability		
	IV. Operationalization. Processing to definition and proportion		
	V. Availability		
	1. Data. Choice of database and unambiguous method of data collection by well-instructed data collectors		
	2. Practice test. Test of measurability and intra- and inter- reviewer reliability		
	VI. Report		
	1. Statistics, tabulations, and data presentation		
	2. Correction for case mix and sociodemographic variables 3. Clear explanations of the results		
	VII. Application to the system of quality improvement		
	1. Feedback with self, external, or standard comparisons		
	2. Analysis and discussion of clinical indicators with a low score		
	3. Analysis of obstructing and conducive factors for providing optimal care		
	4. Formulation of improvement and implementation strategy and carrying out of the project plan		
	5. Monitoring of indicators as measurements of effect and for maintenance of improvement		
	6. Process analysis (was the improvement process carried out as agreed?)		
	Context: N/A		
	Engagement: No Suggested by authors		
	Evidence-based: Unclear		
	Defined population: No (target unclear)		

ID	Scope and Process	Criteria and Measure Characteristics	Criteria to Select Measures
	Validity testing status: Tested Application to the system of quality improvement		

Appendix D. Measure Criteria Component Table

Table D.1. Mapping NHQDR Measure Criteria

ID	Importance	Scientific soundness	Feasibility	Usability	Type of measure	Applicability	Availability	Linkable	Modeling	Balance conditions	Balance sites	State data	Multivariate	Improvability	Measure available	National priority	Value	Population equity	Geo equity	Clinical significance
AHRQ, 2002[21]	No	Yes	No	No	No	No	No	Yes	No	No	No	No	No	Yes	No	No	No	No	No	No
AHRQ, 2011[42]	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No
AHRQ, 2018[22]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
Al-Ghamdi, 2023[23]	No	No	No	No	No	Yes	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No
Ashton, 2015[26]	No	No	No	No	No	Yes	No	No	No	No	No	No	No	Yes	No	No	Yes	Yes	No	Yes
Bardehle, 2002[28]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No
Barton, 2020[29]	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No
Batelle, 2023[30]	Yes	No	Yes	No	No	Yes	No	No	No	No	No	No	No	Yes	No	No	No	No	No	Yes
Behrouzi, 2019[31]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Belgian Health Care Knowledge Center, 2013[32]	Yes	No	No	No	No	No	No	No	No	No										
Berg, 2005[33]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	Yes
Blozik, 2018[34]	Yes	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No
Braspenning, 2005[35]	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Campbell, 1998[37]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Campbell, 2011[36]	Yes	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Canadian Institute for Health Information, 2005[38]	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Canadian Institute for Health Information, 2006[39]	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	Yes
Carinci, 2015[40]	Yes	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
Casey, 2013[41]	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
CMS, 2022[43]	No	No	No	Yes	Yes	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	Yes
Committee on Quality Measures for the Healthy People Leading Health Indicators, 2013[44]	Yes	Yes	No	No	No	Yes	No	No	No	No	No	Yes	No	Yes	No	No	No	No	Yes	No
Commonwealth Fund, 2004[127]	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No
Connor, 2022[104]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No
Council of Australian Governments, 2011[27]	Yes	Yes	No	No	No	No	Yes	No	No	No	No	No	No	No	Yes	No	No	No	No	Yes
Crampton, 2004[45]	Yes	No	Yes	Yes	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	Yes
Davis, 2013[46]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Ehreth, 1994[48]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Etches, 2006[49]	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

ID	Importance	Scientific soundness	Feasibility	Usability	Type of measure	Applicability	Availability	Linkable	Modeling	Balance conditions	Balance sites	State data	Multivariate	Improvability	Measure available	National priority	Value	Population equity	Geo equity	Clinical significance
Evans, 2009[50]	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	No	No	No	No	No
Fisher, 2013[52]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No
Flowers, 2005[53]	Yes	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Haj-Ali, 2017[55]	No	No	No	No	No	Yes	No	No	No	No	Yes	No	No	Yes	No	No	Yes	No	No	Yes
Ham, 2015[58]	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Hatef, 2018[59]	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Hearnshaw, 2001[60]	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	Yes	No	No	Yes	Yes	No	No	No	No	Yes
Institute of Medicine, 2005[63]	Yes	Yes	Yes	No	No	No	No	Yes	No	No	No	No	No	No	No	Yes	No	No	No	No
Irish Department of Health, 2013[64]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Jencks, 2000[65]	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	Yes
Katz, 2004[108]	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	Yes
Kazandjian, 1995[66]	No	No	No	Yes	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No
Kmetik, 2007[68]	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
Kramers, 2003[69]	No	Yes	No	No	No	No	Yes	Yes	No	No	No	No	No	Yes	No	Yes	No	No	No	No
Kringos, 2010[70]	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No
Lawthers, 1995[71]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
Lee, 2007[72]	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	Yes
Lester, 2010[73]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Levitt, 2010[109]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Levitt, 2014[74]	Yes	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No
Li, 2023[75]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Ludlow, 2022[76]	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
MacLean, 2018[77]	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	No	Yes	No	Yes	No	No	No	No	No	Yes
Mainz, 2004[78]	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
Marshall, 2004[80]	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
Matos, 2021[81]	Yes	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No
Mattke, 2007[82]	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
McGlynn, 1998[85]	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	Yes
McGlynn, 1998[84]	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
Mears, 2011[86]	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No
Meltzer, 2014[87]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Michel, 2020[88]	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	Yes	No	Yes	No	No	No	No
Nadzam, 1993[90]	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
National Academies of Sciences, Engineering, and Medicine, 2019[91]	Yes	Yes	No	No	No	Yes	No	No	No	No	No	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes
National Association of County and City Health Officials, 2018[93]	Yes	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

ID	Importance	Scientific soundness	Feasibility	Usability	Type of measure	Applicability	Availability	Linkable	Modeling	Balance conditions	Balance sites	State data	Multivariate	Improvability	Measure available	National priority	Value	Population equity	Geo equity	Clinical significance
National Health Center for Statistics, 2018[94]	Yes	Yes	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	Yes	Yes
National Health Ministers Benchmarking Working Group, 1996[95]	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
National Health Performance Committee, 2001[96]	Yes	No	Yes	No	No	Yes	No	Yes	No	Yes	No	No	No	Yes	No	No	No	Yes	Yes	Yes
National Quality Forum, 2009[100]	No	No	No	Yes	No	No	No	No	No	No	Yes	No	No	Yes	Yes	No	No	No	No	No
National Quality Forum, 2012[98]	No	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	Yes	No	Yes	No	Yes
National Quality Forum, 2023[97]	Yes	Yes	Yes	Yes	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	Yes
NHS, 1999[102]	Yes	No	No	Yes	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No
NICE, 2019[51]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No
NQF, 2002[128]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	Yes	No	No	No	Yes
NQF, 2024[129]	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Pap, 2022[106]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Perera, 2007[107]	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes
Reeve, 2015[110]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Reiter, 2011[111]	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Remington, 2015[112]	Yes	No	No	Yes	No	Yes	No	Yes	No	No	No	No	No	Yes	No	No	No	No	No	No
Rezapour, 2019[113]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	Yes	No	No	No	Yes
Riehle, 2007[114]	Yes	No	Yes	Yes	No	Yes	No	No	No	No	No	Yes	No	Yes	Yes	No	No	No	No	Yes
Rohe, 1999[115]	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No
Rushforth, 2015[116]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No
Schange, 2021[117]	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Schoen, 2006[118]	No	No	No	No	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No
Schoenmakers, 2015[119]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Simou, 2014[120]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Smith, 2010[121]	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Stelfox, 2013[122]	Yes	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Sutcliffe, 2012[125]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	Yes	No	No	Yes	Yes
ten Asbroek, 2004[126]	Yes	No	No	No	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Valentine, 2008[134]	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
van den Berg, 2014[135]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	Yes
Veillard, 2004[138]	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Veillard, 2005[136]	Yes	No	No	Yes	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No	No
Veillard, 2017[137]	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No	No
Wollersheim, 2007[139]	Yes	No	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No

Note: The table shows identified approaches in alphabetical order, mapped to three general measurement criteria (objectivity, reliability, validity), followed by assumed criteria used for the NHQDR to 2010 (importance, scientific soundness, feasibility, usability, type of measure, plus 4 secondary criteria and 4 balancing principles), followed by criteria recommended for the NHQDR in 2010 (improvability, sound measure available, applicability to national priorities; and either value, population equity, or geographic and health systems equity)