



TO: NQF Members
FR: NQF Staff
RE: Voting Draft Report: *National Voluntary Consensus Standards for Population Health: Phase II*
DA: August 30, 2012

Background

Population health is the collective well-being and functional ability of an identified group of people to experience their full capabilities. Population health is generally understood as a systems-level concept that describes health outcomes as measured through a broad spectrum of public health, clinical care, and socio-economic determinants. Population health not only focuses on disease across multiple sectors, but also health and wellbeing, prevention and health promotion. Identifying valid and reliable measures of performance across these multiple sectors can be challenging. Data collection, health assessments at individual and aggregate levels, payment structures, quality of patient care and public health interventions, and other components present challenges in shaping widespread, standardized implementation of population health measures, but overcoming these challenges is critical to any strategy to understand and improve it.

Given the multi-dimensional focus of population health, developing activities to strengthen the measurement and analysis of population health trends can be best accomplished using a collaborative approach that includes public health, healthcare delivery systems, and other key sectors whose policies influence health; inadequate preventive and behavioral choices can have significant negative impact on health outcomes and economic stability, and these along with other determinants contribute to sixty percent of American deaths.

The Population Health project seeks to expand NQF's portfolio of preventive services and broader population health measures. The project has been conducted in two phases. The first phase focused on provider-level preventive services and immunization measures. This current phase assesses provider and population-level measures, including those that focus on healthy lifestyle behaviors and community interventions that improve health and well-being, as well as social and economic conditions. The recommended measures include three that were endorsed prior to 2009 that are undergoing endorsement maintenance.

An 18-member Steering Committee representing a range of stakeholder perspectives was appointed to review a total of nine candidate and endorsement maintenance standards for quality performance in population health in this phase. The Steering Committee is recommending five measures.

Comments and Revised Voting Report

The five recommended measures were available for a 30-day public and Member comment period from July 19 through August 17, 2012. NQF received 28 comments from 10 member organizations, representing a variety of stakeholders.

A table of complete comments submitted during the period, with the responses to each comment and the actions taken by the Steering Committee and measure developers, is posted to the [Population Health Measures Endorsement Maintenance: Phase II project page](#) under the Public and Member Comment section.

The revised draft document, *National Voluntary Consensus Standards: Population Health Endorsement Maintenance: Phase II* is also posted on the [Population Health project page](#) on the NQF website along with the following additional information:

- [Measure submission forms](#)
- [Meeting and call transcripts and recordings](#) from the Steering Committee's discussions.

Revisions to the draft report and the accompanying measure specifications are identified as redlined changes. (NOTE: Typographical errors and grammatical changes have not been redlined to assist in reading.)

Comments and their Disposition

The Steering Committee reviewed the comments and focused its discussion on recurring concerns, specific measures and topic areas that were most controversial or that questioned positions the Committee had taken. Comments about the measures were forwarded to the measure developers, who provided responses. The Committee made no changes to its measure recommendations.

Many of the comments were supportive of the Steering Committee and NQF's work with the Population Health: Phase II Endorsement Maintenance measures. However, several themes emerged from the general comments including:

- Need for a more comprehensive list of population health stakeholders as partners in population health measure development;
- Need for greater collaboration and data sharing across and between the public health and clinical care systems; and
- Recommendations for future measure development.

Theme 1: Need for a more comprehensive list of population health stakeholders as partners in population health measure development

The Committee received additional recommendations for potential partners in population health measurement development including school systems, social science researchers, and patient advocacy groups.

ACTION TAKEN: The Committee appreciated these recommendations and suggested their inclusion in the draft technical report.

Theme 2: Collaboration and data sharing across and between the public health and clinical care systems

There is general consensus for better and increased data sharing across the public health and clinical care systems.

ACTION TAKEN: The Committee agreed with the comments and believes that through this consensus development project and future population health initiatives, there will be increased opportunities and interest for collaboration within and between systems.

Theme 3: Recommendations for Future Measure Development

The majority of general comments were related to recommendations for future measure development. There was overwhelming support for more population or community-level measures that focus on functional health status and health and well-being within built environments (e.g. schools).

ACTION TAKEN: The Committee agreed with the comments and suggested their inclusion in the draft technical report.

Specific measure concern/or topic area

2020: Adult Current Smoking Prevalence (Legacy/CDC)

This measure was revised following the May 30-31, 2012, Population Health: Phase II in-person meeting. The Committee was concerned that the measure as previously specified could not be assessed at lower levels of aggregation such as the state or county. (The initial measure submission utilized the CDC's National Household Interview Survey (NHIS) smoking prevalence questions.) The revised submission utilizes the CDC's Behavioral Risk Factor Surveillance Survey (BRFSS) questions for smoking prevalence, which can be assessed at the state level.

Comments for this measure included:

- Given that this measure is based on patient reported data, we are concerned with the validity and accuracy of patient responses across different populations.

- It is unclear whether testing data reveal any systematic biases in responses for different populations and if responses have been validated for accuracy as part of measure testing.
- We agree with the Committee's recommendation to harmonize this measure with NCQA's measure #0027 Medical assistance with smoking and tobacco use cessation.
- We agree with the Committee's recommendations that those serving in the military should be included in the denominator.
- We agree that smokeless tobacco should be included in this measure.

The measure developer addressed these concerns accordingly:

- The developer confirmed that the measure assesses members of the population and not patients. The developer added that in general, self-reported smoking status is a valid indicator of population-level smoking prevalence and most national surveys in the United States that assess health behavior rely on self-reported data, such as NHIS.
- In reference to the concern raised about the systematic biases in responses between different populations, the developer cited a study that examined potential gender differences in self-reported smoking data. Although there were some differences in self-reporting of smoking status by gender, the results were similar between self-reports and the biochemical tests. The developer believes these findings affirm that self-reports are credible data sources for smoking behaviors among both men and women in large population-based health surveys.
- On the issue of harmonization with measure 0027, the developer explained that these measures assess different aspects of smoking and/or tobacco use. For example, the denominator population for measure 0027 includes health plan members that currently use tobacco and those that have received tobacco use and smoking cessation advice during a specific time period. Measure 2020 assesses current smoking prevalence (only) among the adult population in the United States. Therefore, harmonization would not be practical or necessary.
- While the BRFSS does not include military personnel in their sample, the developer stated that an assessment of smoking prevalence within this population is important, stating further that there is no reason that this measure would not accurately assess smoking status in military populations or that the validity of self-reported smoking status would differ in this population as compared to the more general population. The developer cited several studies that have examined smoking status in a military population and have relied on self-reported data, using measures similar to the BRFSS.
- Finally, the developer explained that including smokeless tobacco would require a separate measure, with specific reliability and validity testing. They note that the smoking prevalence measure is thoroughly tested and has been in use for several years.

ACTION TAKEN: The Committee accepted the developer's responses and did not change their endorsement consideration. However, the Committee agreed that military personnel and smokeless tobacco are important assessments to add to the future iterations of the measure.

0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (CMS/Quality Insights of Pennsylvania)

One commenter suggested that the upper limit BMI cutoff should be >30 for patients of all ages as supported by the recent evidence-based clinical guidelines from the USPSTF.

The developer (CMS and Quality Insights of Pennsylvania) cited recent USPSTF clinical guidelines that recommend providers refer individuals with a BMI > 30 to intensive, multicomponent behavioral interventions. (Obesity, within this guideline, is defined as a BMI > 30. Overweight is defined in the population aged <65, as a BMI > 25 and < 30.) The developer's technical evaluation panel (TEP) strongly believed that providers should be more proactive in interventions to prevent eventual progression from overweight to obesity. Therefore, the scope of this measure outlines calculated BMI and follow-up interventions for overweight, obese and underweight populations.

ACTION TAKEN: The Committee accepted the developer's response and did not change their endorsement recommendation.

0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (NCQA)

Comments for this measure include:

- Measure should capture the BMI score.
- Ensure that the age range is harmonized with the Meaningful Use measure, which defines the denominator population as 2-17 years of age.
- Include quantifiable data like physical activity levels achieved by the patient or time spent counseling the patient.

The measure developer addressed these concerns accordingly:

- While the measure does not capture an actual BMI score, it does require that a BMI percentile be documented. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
- The measure submitted for Meaningful Use calculates age according to the age of the patient at the beginning of the measurement period, whereas the measure submitted for NQF endorsement consideration, calculates age as of the end of the measurement period. The age parameters in the Meaningful Use specifications were adjusted to capture the same age group of patients across reporting program types.

- The developer stated that they appreciate the recommendation to include quantifiable data and will explore options for future measure development.

ACTION TAKEN: The Committee accepted the developer's responses and did not change their endorsement considerations; however, they strongly believed that there should be greater alignment between the age range used in the Meaningful Use measure (2-17) and the current measure under NQF endorsement consideration (3-17) in order to lessen the confusion with the measure specifications. Furthermore, the Committee agreed that assessment of BMI level is an important future enhancement to this measure.

0029: Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity (NCQA)

Commenters recommended that the developer revise the measure to include quantifiable data such as physical activity level achieved by the patient or time spent counseling the patient, in addition to asking the patient if they made changes to their level of physical activity.

The Developer appreciated the recommendations and agreed that the measure would be strengthened if it evaluated patient reported change in physical activity level. They will explore these avenues in the future.

ACTION TAKEN: The Committee accepted the developer's response and did not change their endorsement recommendation.

1999: Late HIV diagnosis

Commenters suggested that this measure, which identifies high risk patients, would provide more beneficial information if it were stratified by age, race/ethnicity, and transmission category. This would allow the measure to address well-documented disparities. Commenters also suggested the measure should be reported at the facility-level.

- The developer confirmed that this measure can be used at the facility-level in closed systems, for example the VA or Kaiser Permanente, which provide the full range of healthcare services; however, they do not think it would be a useful measure for a facility where people who may not have been in regular care, seek care when they become symptomatic. The developer believes that as integration of care improves under healthcare reform, the measure will become increasingly useful at the healthcare system level.

ACTION TAKEN: The Committee accepted the developer's responses and did not change their endorsement recommendation.

NQF Member Voting

Information for electronic voting has been sent to NQF Member organization primary contacts. Accompanying comments must be submitted via the online voting tool.

Please note that voting concludes on September 13, 2012 at 6:00 pm ET – no exceptions.