NATIONAL QUALITY FORUM

Meeting Summary

Prevention and Population Health Standing Committee Web Meeting

The National Quality Forum (NQF) convened a public web meeting for the Prevention and Population Health Standing Committee on June 27, 2019.

Welcome, Introductions, and Review of Web Meeting Objectives

Debjani Mukherjee, NQF Senior Director, welcomed participants to the web meeting. Ms. Mukherjee provided opening remarks and reviewed the following meeting objectives: (1) defining value-based care for population health, since the existing definitions from other sources largely focus on either cost and/or are clinically focused; and (2) discussing potential steps and considerations necessary to harmonize three CMS-developed influenza measures within the Committee's portfolio. These specific influenza measures are:

- 0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay) (CMS)
- 0681 Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) (CMS)
- 1659 Influenza Immunization (CMS)

Defining Value-Based Care for Population Health

The Committee first addressed the IOM definition of value for population health provided by NQF staff: "The intersection and consideration of cost versus clinical. The focus is to improve health and lower costs by measuring most crucial health outcomes as a guide for assessing the impact."[1] In a wide-ranging discussion, the Committee agreed on the need to address definitional issues, including the following points:

- Overall, the Committee generally agreed that the definition of value could be defined as a comparison between benefit versus cost plus harm, regardless of whether the focus was on population health versus individual health.
- Population health management (delivery of care) is very different from population health, with the former addressing individuals' needs and the latter being more broad, where social determinants of health are an integral part of capturing and assessing value in a community setting.
- Benefit was identified as the key component to define, wherein different perspectives on and/or quantification of value depend on how benefits are defined and measured—i.e., value to whom? The frame of reference is important, so a "calculated" value might

[1] Institute of Medicine. *Vital Signs: Core Metrics for Health and Health Care Progress.* The National Academies Press; 2015. https://www.nap.edu/catalog/19402/vital-signs-core-metrics-for-health-and-health-care-progress. Last accessed July 5, 2019.

change because of differing emphasis or changes to weights for benefit(s), but the equation is the same. Additionally, for future discussion, the point was raised that one approach to defining "benefit" is that it must contribute to length of life or have impact on the quality of life; the quality of life contribution could be related to specific morbidity or to broader definitions of well-being and needs further discussion and definition.

- While theoretical at this point, the Committee should consider whether specific scenarios would/could/should change the current working definition of value.
- Definitions for population health (e.g., within a clinical setting versus a geographic area), community health, and public health also should be set forth.

Given how value depends on point of view, the Committee noted that value changes based on the measured entity and that the definition needs to address specific target audiences, such as patient, provider, payer, population level, and community. Additional granularity could also be important—e.g., the community perspective can be further parsed into clinical value and social services, along with social determinants of health. However, the Committee members clarified that for the population health portfolio, the frame of reference is the population level and so the frame is a societal one.

The Committee noted that ascertainment of value at the population level requires appropriate attribution. The issue of attribution is fundamental to measurement, but usually is not focused on population health measurement. Therefore, population-focused value and attribution need to be clearly delineated, especially given the limited contribution of clinical care/healthcare to health. Committee members highlighted this point by noting that most of health is affected by factors outside of the clinical care system. Therefore, determination of value at the population health level is predicated on clinical, nonclinical, and societal factors. As a result, existing attribution models are difficult to apply, since attribution often focuses on individual providers or settings. Moreover, the type of provider and service varies—e.g., legal, educational, or social services. This breadth makes measure development in the population health space difficult, and this difficulty is compounded by a lack of incentive because there is no use case for such measures. The Committee also highlighted the need for a lifespan-focused lens of value since population health covers the spectrum of health from birth to death and involves multiple systems over this timespan. NQF staff acknowledged that attribution is a limiting issue when we try to assess population health through measurement and noted that NQF is further delving into this matter through other work.

With respect to next steps, NQF staff noted that, in addition to a summary of the Committee's discussion, NQF staff would prepare additional information to continue the Committee's deliberations on its next strategic webinar, scheduled for September 18, 2019. Committee members recommended reviewing additional ongoing and recent work when preparing the webinar material. Toward that end, Committee members recommended that, in addition to addressing definitional issues, the Committee could develop guiding principles, and perhaps also criteria, to identify those measures that are critical for the population health of the nation. For example, there are a few preventive services for which the cost of the service delivery results cost savings (e.g., childhood immunization, smoking cessation). Most measures/measurement

targets, however, will be degrees of cost, benefit, and harm and require clear guidance to determine what is critical. It also was suggested that the Committee's portfolio should be examined against any guidance, and that such guidance also would be useful to other topic areas/Committees when evaluating measures.

NQF staff thanked the Committee for its rich discussion. Staff noted that they view the Committee's work on this issue as an iterative process and that they now have a good sense of the Committee's initial thoughts on value and population health measurement.

Harmonization of Influenza Measures

The Committee discussed harmonizing three influenza measures: 0680 *Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)* (CMS), 0681 *Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)* (CMS), and 1659 *Influenza Immunization* (CMS).

Previously, the Committee recommended the creation of a universal influenza measure to reconcile and harmonize the large number of influenza measures in use. During this meeting, the Committee discussed the harmonization of 0680, 0681, and 1659 as an initial step towards this goal since all of the measures have the same steward, the Centers for Medicare and Medicaid Services (CMS), and are specified for the facility level of analysis. As currently specified, the three measures are well aligned with a few differences in the exclusion criteria. For instance, 1659 excludes patients who died prior to discharge while 0680 and 0681 do not. Nonetheless, the Committee felt strongly that the measures were not sufficiently different in the population measured, the data sourcing, the level of analysis, or the care setting to warrant three separate measures. The developers stated that they could more fully harmonize the measures but need additional direction and guidance from their contractor, CMS.

The three measures are up for maintenance of endorsement in 2020. The Committee recommended that the three measures be fully harmonized by the 2020 submission to a universal measure of influenza. If the measures are not harmonized by the 2020 submission, the Committee will consider not re-endorsing. NQF will discuss this recommendation with the measure steward, CMS.

Public Comment

Kate Buchanan, NQF Senior Project Manager, opened the web meeting to allow for public comment. No public comments were received.

Next Steps

NQF will reconvene the Standing Committee via a web meeting for another strategic discussion on September 18, 2019. The Committee is expected to review performance measures during the upcoming fall 2019 cycle.