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Office of Prevention through Healthcare,
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ATTN: Health Risk Assessment Guidance.

On behalf of the National Committee for Quality Assurance (NCQA), I appreciate the opportunity to respond to your request for information on developing guidance on Health Risk Assessments (HRAs). As America’s leading HRA certifier and Wellness and Health Promotion (WHP) program accreditor, we strongly support developing guidelines for effective use of HRAs.

Medicare’s new coverage for physician-administered HRAs in connection with Annual Wellness Visits will also carry tremendous benefits for seniors and public health research. We encourage you to integrate HRAs with other public health programs, administering surveys at worksite, physician and plan levels.

NCQA offers three programs that relate to your efforts in connection with HRAs:

1. **Certification of Health Information Products** (of which an HRA is one product). We certify vendors offering HRAs that:
   1. Collect a range of health characteristics and behavioral information;
   2. Contain explicit privacy disclosures and consent requests;
   3. Provide actionable feedback to participants;
   4. Are administered in an accessible way;
   5. Are administered to individuals annually; and
   6. Are updated on a bi-annual basis as the evidence base evolves.

2. **Accreditation of Organizations Providing Wellness and Health Promotion (WHP) Programs.** To receive NCQA’s WHP accreditation, organizations must administer HRAs that comply with standards similar to those under our Health Information Product certification program. However, HRAs are just one component of successful organizations’ suite of WHP services, which plan sponsors generally offer within the employer-based benefit context. We accredit organizations that offer WHP programs for providing a variety of services to plans and employers supporting HRA and health improvement goals. Other WHP services include collecting and reporting performance measures, proffering incentive-based health improvement plans, targeting at-risk individuals for intervention, health coaching, and others.
3. **Patient-Centered Medical Home (PCMH) Recognition.** We have updated our Patient-Centered Medical Home Recognition program with new standards for 2011 that require HRAs. We do not prescribe how recognized practices conduct HRAs, but do require that they include medical histories, immunizations, screenings, cultural characteristics, advance care planning, behaviors affecting health, and more.

Leveraging our expertise in evaluating and certifying these programs and products over the past several years, we offer the following responses to questions posed in the request for information.

**Content and Design:** *What are generic elements of any HRA and what elements must be tailored to specific populations, particularly those stratified by age? How should literacy and other cultural appropriateness factors be factored into the design? How should the HRA instrument support shared decision-making by provider and patient?*

We certify organizations offering HRAs based on whether they include questions:
1. On demographics, including race and ethnicity;
2. On personal and family history, including chronic illness and current treatment;
3. On self-perceived health status, including functional status;
4. To identify effective behavioral change strategies; and
5. To identify any special hearing or vision impairment and language needs.

They also must be able to collect personal health characteristics: weight; height; smoking; physical activity; healthy eating; stress; productivity or absenteeism; breast cancer screening; colorectal cancer screening; cervical cancer screening; influenza vaccination; risky drinking; and depressive symptoms. All certified administrators of an HRA must present the assessment in language that is easy to understand. The organization must present information in a clear and coherent manner and use words with common and everyday meaning, to the extent practical.

**Mode of Administration:** *How will individuals access the HRA (e.g., via kiosk or some other means in the physician’s office, Internet, mail-in paper form, other non-traditional healthcare locations, such as, kiosk in a pharmacy)? What are the cultural appropriateness factors in patient HRA access?*

Currently, employers commonly sponsor HRAs at worksites, and we should ensure appropriate sharing of results with primary care providers to avoid duplicate HRAs. NCQA-certified organizations must offer HRAs either online or in print and by telephone and in easy-to-understand language. We also support physician office HRAs as part of both new Medicare wellness visits and PCMH Recognition. NCQA’s WHP standards require organizations to assess language needs and be transparent about their ability to support other languages. PCMH standards also require an assessment of the patient’s cultural characteristics. This helps ensure that WHP programs can support employees for whom English is not their first language.
Consumer/Patient Perspective: How could HRA data be shared with the patients for their feedback and follow up in the primary care practice? What role, if any, do incentives play in motivating patients to take the HRA and/or participate in follow-up interventions?

NCQA-certified HRA organizations must share the following results with each participant:
1. An overall summary of their own individual risk or wellness profile;
2. A clinical summary describing individual risk factors;
3. Information on how to reduce risk by changing specific health behaviors;
4. Reference information that can help the participant understand the HRA results; and
5. A comparison to previous results when applicable.

With patient consent, primary care providers should routinely get HRA findings so they can help address findings. WHP accredited systems also must offer a number of supports for health improvement. These include self-management tools, opportunities to engage in employer-sponsored activities (walking clubs, smoking cessation), health coaching, etc. The WHP organization must also conduct targeted follow-up with specific at-risk participants, such as hypertension, possible addiction or depression, or other risk factors. Follow-up may include discussion of preventive health services information or supports.

Evidence suggests that incentives for completing HRAs can increase completion rates. This helps WHP programs reach more participants and gives the organization a better understanding of the population’s risk profile. Without incentives, response rates are extremely low.

Data: With respect to Information Technology (IT), how could HRA data entered in any form populate electronic health records, and what special challenges and solutions occur if the data are entered in a non-electronic form? Are there standardized and certified tools available to support this data migration from multiple data entry sources?

Data integration and exchange to combine health data from disparate sources into a unified portrayal of an individual’s health status is a core component of any comprehensive wellness program. This is why we require accredited WHP organizations to disclose data integration and exchange capabilities for the following sources:
1. Claims or encounter data;
2. Demographic data;
3. Lab or biometric data;
4. Pharmacy benefit management organizations;
5. Disease management organizations;
6. Managed behavioral health organizations;
7. Medical providers; and
8. Data aggregators.

We require data exchange and reporting standards within our evaluation products to spur integration and representation of these data. However, we believe more is needed to ensure a universal standard. We therefore support Office of the National Coordinator for Health IT work towards a universal data exchange platform for all information, including HRAs.
**Certification:** What certification tools and processes should complement the HRA guidance and how should they be made available to support primary care office selection of an HRA instrument?

NCQA accreditation and certification are the most widely used tools to evaluate both HRAs and WHP programs. We developed our standards in consultation with a cross-stakeholder advisory committee and our Board of Directors, which both include academics and researchers, physician leaders, health plan representatives, consumer advocates, and others. Using NCQA’s standards would foster industry-wide consistency and help NCQA evaluated programs – particularly those used by small employers – to coordinate with federal initiatives.

**Evaluation and Quality Assurance:** How should the HRA guidance be evaluated and updated with respect to individual and population-level (practice-based panel management) health outcomes?

NCQA requires accredited organizations to have quality improvement processes in place to identify, measure and act upon improvement opportunities. This could inform your efforts.

Thanks again for the opportunity to comment. We look forward to working with you further to expand the use of effective, evidence based HRAs.

Sincerely

Margaret E. O’Kane
President