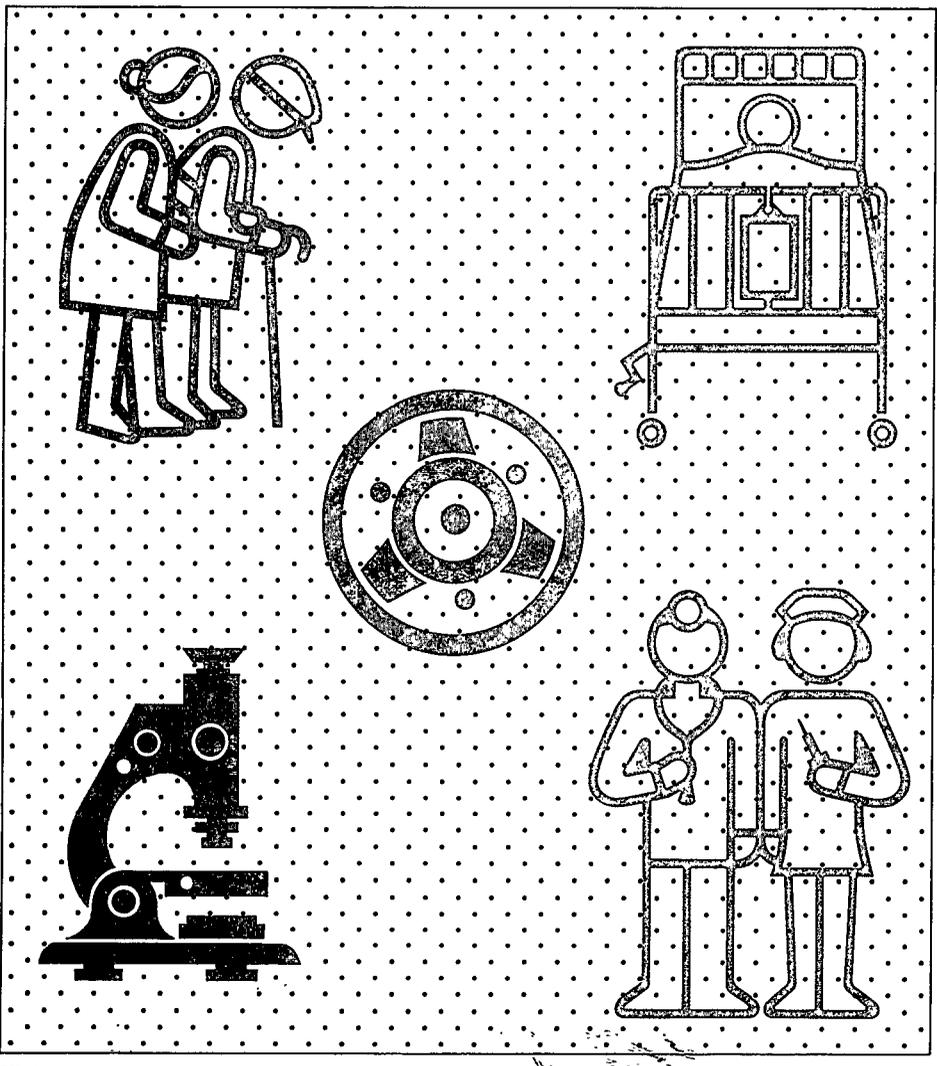


# The National Committee on Vital and Health Statistics

1986

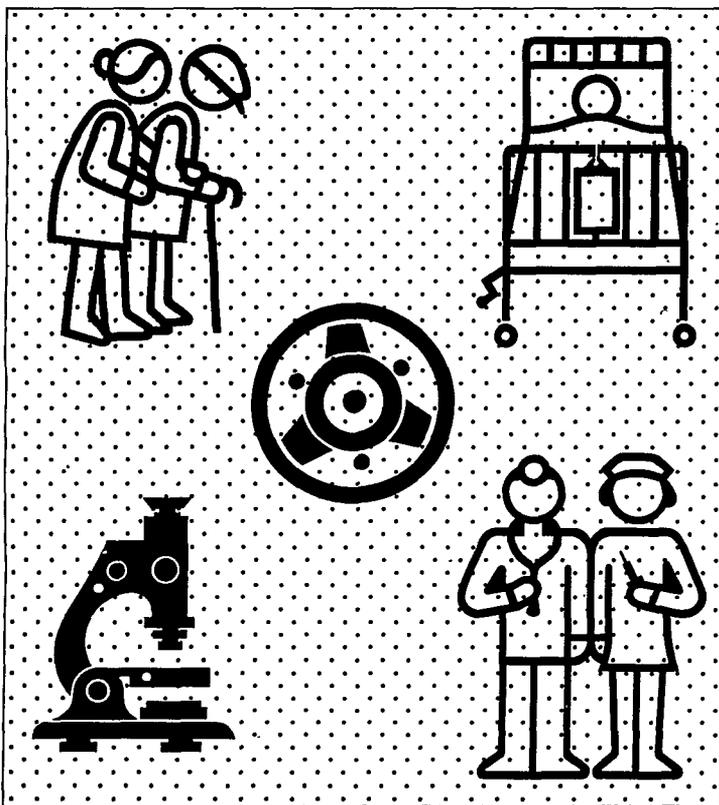


U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service • National Center for Health Statistics



# The National Committee on Vital and Health Statistics

1986



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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
National Center for Health Statistics

Hyattsville, Maryland  
June 1987

# NATIONAL COMMITTEE ON VITAL & HEALTH STATISTICS

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RONALD G. BLANKENBAKER, M.D.  
CHAIRMAN

GAIL F. FISHER, Ph.D.  
EXECUTIVE SECRETARY

The Honorable Otis R. Bowen, M.D.  
Secretary, Department of Health and  
Human Services  
Washington, D.C. 20201

Dear Secretary Bowen:

On behalf of the National Committee on Vital and Health Statistics (NCVHS), I am pleased to transmit the 1986 Annual Report as required by the Committee's Charter.

This has been a productive year for the National Committee, both through the work of its subcommittees and in its broader liaison responsibilities within the Department and with other public and private sector groups.

The report describes the Committee's accomplishments during 1986 and its plans for new and continuing activities in the coming year. The Committee also remains available to assist with emerging health data issues as you may require.

Sincerely yours,



Ronald G. Blankenbaker, M.D.  
Chairman

## Foreword

The last report of the National Committee on Vital and Health Statistics described the Committee's activities from 1983 to 1985. These were important formative years during which the Committee, which had been inactive the previous 2 years, became more broadly oriented in composition as well as direction. In contrast to earlier years of the Committee's activities, the extensive use of outside experts to assist subcommittees with technical studies was significantly curtailed during this period. Consequently, the report reflected the efforts to redirect the activities of the Committee, which is legislatively mandated to advise the Secretary of the Department of Health and Human Services, by placing emphasis on the most efficient use of Committee resources in areas deemed to be of the most benefit to the Department.

The current report, which reflects the Committee's activities during the 1986 calendar year, summarizes work that benefited greatly from the previous Committees' efforts. Several developments of 1986 are worthy of emphasis. First, the Committee reassessed its charter and mission with the determination that its responsibilities are indeed very broad and cover the total spectrum of health statistical issues at the national and international levels. Recognizing that this is a formidable task, the Committee reoriented itself so that it could maximize its efforts. This was done through a more flexible structure that utilizes short, informative updates from various departmental and outside agencies and individuals. Adopting this approach, a series of issues and programs have been designated for regular reports to the Committee to keep it up to date on current and anticipated health statistical matters. From this information the Committee is developing a dynamic 2-year workplan that will be modified on an annual basis.

Second, the Committee has moved to strengthen its role and voice as a representative of the private sector's interest and concerns regarding health data collection, analysis, publication, and interpretation. This is being accomplished both through the broad perspective of its membership, which consists of 15 individuals who are selected by the Secretary from among persons who have distinguished themselves in such fields as health statistics, health planning, epidemiology, and the provision and financing of health services, and by serving as a forum for data issues which significantly involve the private sector. The views and concerns that surface are being conveyed through regular meetings and communications with appropriate officials within and outside the Department. Special attention has been given to the relationships between the Committee and the Office of the Assistant Secretary for Health, through which the Committee communicates to the Secretary; the Office of the Director of the Health Care Financing Administration (HCFA); and the National Center for Health Statistics (NCHS). Statements on activities, issues, and policies will be provided as issues arise.

Third, the subcommittee, or working group structure of the Committee, is being maintained and strengthened so that a maximum number of issues can be addressed within resource limitations. However, these efforts are being oriented toward 1-year and 2-year goals, with the view toward completion within 2 years at the most. Additionally, individual Committee members have been designated as representatives or monitors of areas or issues that do not currently require a working group or subcommittee but are of high interest to the Committee. The full Committee is being regularly updated on these activities and is applying a rigorous evaluation procedure to each issue to determine its priority within the Committee's workplan. The newly established Executive Subcommittee is providing overall coordination to the activities of the Subcommittees and the individual monitors.

Finally, the Committee has begun to work closely with NCHS in its annual publication *Health, United States*. This process is encouraging Committee members to keep abreast of current health statistical developments, and it also gives the Committee an opportunity to provide input to the most significant statistical reference book on health that is currently available.

Within this setting, the Committee addressed a number of issues in 1986 that are detailed within this report. Each warrants a brief comment here. A milestone report on the Statistical Aspects of Physician Payment Systems was completed after the receipt and assimilation of testimony from a wide variety of sources. The Subcommittee working on this issue did a superb job of defining the data requirements (and their complexities) of the users of data from patient-physician encounters in the ambulatory care setting. It was recommended that all items in the Uniform Ambulatory Medical Care Minimum Data Set be thoroughly and systematically reviewed for the purpose of developing a revised version that meets current needs. The report and the recommendations it contains should have a significant impact on information related to any changes in the reimbursement mechanisms for physicians. The Committee transmitted the report to the Assistant Secretary for Health, who circulated it to the departmental Health Information Policy Council (HIPC) for review and comment. The Assistant Secretary and the HIPC, which he chairs, have generally endorsed the report, and the Committee anticipates working with the Department in the coming year on the recommended review of the Minimum Data Set.

The Subcommittee on Disease Classification and Automated Coding of Medical Diagnoses is reviewing comments on the Tenth Revision of the International Classification of Diseases (ICD-10), and it will participate actively in the development of the final version of ICD-10. This Subcommittee also will monitor activities in the area of international health data and will provide regular reports to the Committee. Similarly, the Subcommittee on Uniform Minimum Health Data Sets has been evaluating the Long-Term Care Minimum Data Set and, in the process, has developed some serious reservations about the usefulness of a single minimum data set in the long-term care industry. A final report will be forthcoming by June 1987.

The Subcommittee on Minority Health Statistics was very active in the development of the rationale for the standardized Hispanic identifiers on vital records, which will have an important impact on health data collection for this population in the future. The Subcommittee is reviewing the current and planned Department of Health and

Human Services' data collection systems, and it will assess the ability of these systems to produce data on access to and financing of medical care for minority populations and the medically indigent. A final report on these very significant issues will be made in the fall of 1987.

The Subcommittee on Data Gaps in Disease Prevention and Health Promotion has determined that much is being done at the national level to address the needs in this area, yet few, or only fragmented, efforts are being made at the local or State level to collect data on disease prevention and health promotion activities. Furthermore, the data that are collected are often not useful for State-to-State or State-to-national comparisons. To resolve this dilemma the Subcommittee will explore the need for an inventory of data bases (local, State, and national), address the effectiveness of primary data versus model-based estimates for local or State needs, and develop strategies that will encourage the use of shared expertise on the local, State, and national levels. A final report on these important activities will be given in June 1987.

The Committee has heard testimony on and is considering the need for a Nursing Minimum Health Data Set. A report will be made to the Assistant Secretary for Health in January 1987. Additionally, the Committee is monitoring the restructuring of health care statistics activities at NCHS, quality of care evaluations at HCFA, efforts to collect data related to catastrophic health care costs, data linkage needs as they relate to specific issues or priorities, and data collection activities for health care of the aging and occupational health. Lastly, the Committee has expressed alarm at the quality of health data that is frequently released by our Government or other agencies with resultant inappropriate or erroneous interpretation on the part of the public. The Committee is reviewing criteria that could be used as guidelines for any agency that wished to evaluate the quality of its data prior to release, and it will assist such agencies in any way it can to assure that quality data and data analyses are disseminated.

This has been a good year—busy, but gratifying. However, the work of the Committee has just begun, and it will continue for many years to come. Sincere appreciation is extended to all the members of the National Committee and to the staff of NCHS along with those throughout the Department who have been stimulating and supportive. With such continued backing, the Committee should easily reach its goals and more!

Ronald G. Blankenbaker, M.D.  
Chairman, National Committee  
on Vital and Health Statistics

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## **Executive Summary**

During 1986, the National Committee on Vital and Health Statistics, in its advisory capacity to the Department of Health and Human Services, accomplished the following activities through the work of its five subcommittees:

- Completed a major report on the statistical aspects of physician payment systems, underscoring the value of standard definitions across data collection systems.
- Developed recommendations, which were accepted by the National Center for Health Statistics, to include in the upcoming revision of the U.S. Standard Certificates of Live Birth and Death a specific item to identify events to persons of Hispanic origin.
- Devoted serious attention to the application of the Uniform Minimum Data Set concept to long-term care and reviewed the content of the current Long-Term Care Minimum Data Set.
- Maintained its role as a forum for the complex issues related to the revision of the International Classification of Diseases.
- Identified the need to focus on data gaps at the State and local levels for planning and evaluating health promotion programs and assessing needs.

In 1987, the Committee will continue efforts related to the above activities and will give priority to the following additional areas:

- Thorough review of the Uniform Ambulatory Medical Care Minimum Data Set.
- Assessment of the ability of the Department's data collection systems to produce information on access to and financing of health care of minorities and the indigent.

The Committee also will monitor and consider recommendations for a variety of health statistical issues that it has identified over the past year as important to the Department and the Nation.

# **Activities, Accomplishments, and Future Plans of the National Committee on Vital and Health Statistics**

The year 1986 was one in which the National Committee on Vital and Health Statistics (NCVHS) strengthened many of the specific activities it had initiated previously and also began to look more broadly at the full range of health statistical issues encompassed by its charge. During this year, the Committee sought to achieve a balance between conducting in-depth studies of a selected number of topics and pursuing at a more general level all of the major health data issues affecting the Department of Health and Human Services and the Nation. The Committee also gave greater attention to its internal organization and procedures, as well as to communications with agencies and officials within the Department. These emphases were facilitated by the active role of the Executive Subcommittee, which was established in November 1985 and held a number of meetings during 1986.

Through the existing subcommittees, the NCVHS continued to pursue work in the following five areas that had been established as priorities in conjunction with the Department:

- Uniform minimum health data sets.
- Disease classification and automated coding of medical diagnoses.
- Minority health statistics.
- Data gaps in disease prevention and health promotion.
- Statistical aspects of physician payment systems.

As directed by the full Committee, the Executive Subcommittee worked with each of the five subcommittees to assure that work plans were developed and specific products were completed or scheduled. The activities, accomplishments, and future plans of the subcommittees are detailed in the subsequent sections of the report. Membership lists and the charges to the subcommittees, as well as meeting dates, are included in appendix IV.

At the same time, the Executive Subcommittee identified a variety of other approaches for dealing with emerging health data issues within available resources, recognizing that subcommittees should be reserved for substantive tasks requiring the participation of several members over a period of at least a year. These approaches, which will permit the Committee to respond to a wider range of issues,

include receiving relevant briefings at full Committee meetings; designating individual members to function as agents of the Committee to monitor particular issues, gather information, and review activities; developing policy statements on key health data issues for submission to the Secretary or the Assistant Secretary for Health; and proposing to departmental officials that selected issues should be addressed by some agency or mechanism within the Department.

As a guide to the full Committee in considering emerging health data issues, the Executive Subcommittee developed a list of characteristics that could be applied to any issue under discussion. These include the statistical and public health importance of an issue, any political implications, and the issue's timeliness and manageability. The characteristics, which are detailed in appendix V, are intended to assist the Committee in clarifying and assessing a particular issue, determining the appropriate level of Committee involvement, and establishing the issue's priority.

Within the above framework, the Committee gave attention to a number of important topics that had been identified by members or staff during the year and agreed to monitor each in the following manner during 1987:

- Adequacy of national health statistical systems and capabilities.

The full Committee will take responsibility for this broad issue, beginning with briefings by individuals knowledgeable about current health data needs and capabilities. The Committee will also work closely with the National Center for Health Statistics (NCHS) on development of *Health, United States*, the Secretary's annual report on the health of the Nation.

- Quality of data and data analyses with particular interest in standards across agencies for the release of data and for the accompanying documentation.

The Committee will work with NCHS to identify existing guidelines for release of health-related data and to determine whether these guidelines are adequate and recognized throughout the Department.

- Policies and opportunities regarding linkage of information from two or more data sets.

The Committee intends to examine these data linkage issues in connection with particular topics under study by subcommittees or individual members.

- Statistics to track trends and assess the impact of new approaches in the health care delivery system.

The Committee will review NCHS plans for restructuring its existing surveys of health care providers, and it has assigned one member to acquire more in-depth knowledge of the survey plans and to monitor current and future developments.

- Data on quality of care and patient outcomes.

The Committee has been briefed by the Health Care Financing Administration (HCFA) on current HCFA-sponsored research, and it will continue to monitor this area.

- Data on the aging population.

One Committee member will serve as liaison to the multiple departmental groups involved in major data collection and use of data on the elderly and will monitor progress in this area.

- Data on uncompensated care and access to care by the medically indigent.

In order to understand current data gaps and future data needs, the Committee received a report from the Secretary's Catastrophic Illness Study Technical Working Groups. The Subcommittee on Minority Health Statistics will include the topic of data on health care for the indigent in its other investigations.

- Data on occupational health.

The Committee will receive periodic updates from NCHS on its activities with the National Institute for Occupational Safety and Health and the Bureau of Labor Statistics in this area and will monitor progress in enhancing the occupational health data base.

- International health statistical activities, including systems development, cross-national comparisons, and collaborative efforts.

In addition to two Committee members monitoring activities in this area, the Subcommittee on Disease Classification will consider expanding its charge to include gathering information related to this topic.

Throughout its activities, whether conducted through subcommittees or on a monitoring basis, the Committee seeks to assure that its work is directly relevant to the concerns of the Department in the health data area. Recognizing that regular interaction with health data policymakers will help increase the Committee's responsiveness to departmental needs, the Chairman held meetings during the year with the Assistant Secretary for Health and the HCFA Administrator to discuss current activities, and he will maintain ongoing communication with these officials and their staffs concerning future work plans and accomplishments. The Committee will also anticipate receiving guidance from the Department on particular issues and will seek every opportunity to respond in a timely and appropriate manner.

The activities, accomplishments, and future plans of each Subcommittee follow.

### **Uniform Minimum Health Data Sets**

The Subcommittee on Uniform Minimum Health Data Sets held meetings on January 17, April 24-25, and July 31-August 1, 1986, continuing its review of the

Long-Term Care Minimum Data Set (LTCMDS). The Subcommittee heard additional testimony from Department staff and received periodic reports on the work of two related departmental task forces, the Interagency Task Force on the LTCMDS and the Interagency Task Force on Long-Term Care Facilities. The bulk of the Subcommittee's effort, however, involved internal discussion of the application of the uniform minimum data set concept to long-term care and a review of the content of the current Long-Term Care Minimum Data Set.

The application of the uniform minimum data set concept to long-term care is difficult and complex. "Uniform minimum health data sets are core minimum sets of items of information with common definitions concerning a specific aspect of the health care system which meet the essential needs of a variety of health data users" (DHHS, Health Information Policy Council, 1983). A uniform minimum health data set is intended for incorporation within administrative systems and surveys of providers and users. Its utility for policy analysis, program management, and basic research must be sufficient to warrant the resources full implementation implies.

Long-term care does not constitute a single specific aspect of the health care system. Rather it encompasses an extremely heterogeneous set of patient subpopulations and provider types. It includes three major subpopulations: physically incapacitated or impaired persons due to age, accident, or disease; chronically mentally ill persons; and persons with mental retardation or developmental disabilities. Each subpopulation receives services from several types of institutional and noninstitutional providers.

Providers range from institutions offering highly skilled professional services to family members with little or no training. Although there is some overlap as single providers serve patients from more than one subpopulation, there is considerable independence among the subpopulations, their needs, and the providers that serve them.

The Subcommittee reviewed the content of the current LTCMDS taking account of the heterogeneity in long-term care and the intended implementation of a uniform minimum data set in both administrative record systems and research and survey activities. Reconciling these factors raised a number of concerns.

Many of the items, either as currently defined or with some refinement, were clearly appropriate for inclusion in a broadly applied LTCMDS. However, for other key items, developing a uniform definition to yield valid comparative data on the different subpopulations seemed impossible. In addition, the relevance of some items for particular subpopulations and the capacity of provider types to supply requested data appeared questionable.

Defining a unit of observation or establishing the frequency with which LTCMDS items should be collected raised additional issues. Other service-oriented minimum data sets—the Uniform Hospital Discharge Data Set and the Ambulatory Medical Care Minimum Data Set—are used to collect information on episodes of care, for example, a hospital stay or an ambulatory care encounter. The relationship between a provider and a long-term care patient or client varies considerably across patients

and over time. Long-term care episodes range in duration from a few days to years, and intensity of service can vary significantly within an episode as patients recover and/or decline.

In light of these issues and concerns, the Subcommittee decided to prepare a summary of its discussion of the items of the current LTCMDS and a statement on the application of the uniform minimum data set concept to long-term care. This draft document will be distributed to Committee members and experts outside the Committee for comment in early 1987. Among the major issues that will be presented for review are:

1. Whether it is useful to continue the development of an implementation of a single uniform minimum health data set for long-term care. Or, alternatively, whether the development of a family of long-term care uniform minimum data sets should be considered. Member data sets would apply to particular provider types that serve predominantly one of the major long-term care subpopulations. Uniformity in definitions for variables contained in more than one minimum data set would be maintained to the greatest extent possible. Utility to the primary users of a single data set would not be excessively sacrificed in pursuing uniformity across the data sets. The potential for a single uniform minimum data set could be reviewed after the individual data sets have been developed and tested.
2. What additional research should be undertaken regarding variables measuring patient conditions or status, for example, activities of daily living, instrumental activities of daily living, and behavioral measures? The value of some of these variables has been well established for some subcomponents of the long-term care population. Application to other subcomponents and validity of inter-group comparisons may need further exploration.
3. How could existing service descriptions be improved so that they reflect differences in resource use and cost? To what extent can existing service coding systems be used, or what steps should be taken to develop appropriate coding systems?

The Subcommittee will review the comments received in preparing its final report on the LTCMDS for consideration by the Committee. The Subcommittee will also fulfill the other elements of its current charge—review of the evaluation of the LTCMDS and of trends in data collection and storage practices in long-term care facilities and include its findings in the final report to the Committee.

### **Disease Classification and Automated Coding of Medical Diagnoses**

The Subcommittee on Disease Classification and Automated Coding of Medical Diagnoses was established in June 1983 to address the complex issues related to the

International Classification of Diseases (ICD) and its multiple uses. The Subcommittee pursued its charge by receiving testimony from numerous public and private sector organizations interested in this subject.

During its initial meetings, the Subcommittee identified considerable concern about the upcoming process for developing the Tenth Revision of the ICD. In response to this testimony, the Subcommittee recommended that the National Committee on Vital and Health Statistics collaborate with the National Center for Health Statistics (NCHS) in presenting three conferences to orient ICD users in the United States about the revision process and to provide them with an opportunity to take an active role. A conference for Federal agencies was held in December 1984, and in May 1985 medical specialty groups and other interested organizations conferred. A third conference is planned that will focus on implementation of ICD-10 from a data collection and processing perspective.

The Subcommittee also heard from various organizations involved with the development, maintenance, and use of procedure codes and learned that the World Health Organization (WHO) had no current plans for additional work on the taxonomy of procedures. In this area, the Subcommittee recommended that a common procedure coding system for the United States be developed that can be used for physician fee-for-services, diagnostic reporting, and hospital inpatient care reimbursement and that will respond to data user needs.

In addition, the Subcommittee consulted with the Department on the development and implementation of new ICD-9-CM codes for human T-cell lymphotropic virus-III/lymphadenopathy-associated virus (HTLV-III/LAV) infections, a manifestation of which is acquired immune deficiency syndrome (AIDS). The new codes were implemented October 1, 1986, for morbidity coding in hospitals, and they will be implemented on January 1, 1987, for mortality coding.

Having accomplished the above, the Subcommittee is continuing to serve as a forum where concerns and interests can be expressed; as a liaison between the private and governmental sectors in health statistics; as a monitor of ongoing activities; and, at times, as conciliator among disputants. In this regard, the Subcommittee consulted with the WHO Collaborating Center for Classification of Diseases for North America, located at NCHS, on the U.S. response to the second draft of ICD-10 and provided an additional opportunity for interested parties to advance their positions on the draft in an open forum.

In addition to monitoring the progress toward the development of ICD-10 and participating in the formulation of U.S. recommendations to the WHO, the Subcommittee intends to carry out the following activities:

- The Subcommittee will seek to determine whether the Tenth Revision will be adequate to meet the clinical needs of this country. If a modification such as that carried out for ICD-9 is deemed necessary, the Subcommittee will advise as to the planning, development, and implementation of such an activity.
- The Subcommittee will monitor activities related to procedure coding and will seek clarification on whether a U.S. revision of Volume 3 will be necessary. In

May 1986, a Subcommittee member attended a meeting that was convened by the Health Care Financing Administration (HCFA) to open discussion among people interested in procedure coding. As a result of that meeting, the American Medical Association (AMA) and the American Hospital Association agreed to co-chair a task force that would outline and set priorities for the objectives of a common procedure coding system. This task force was charged to undertake a thorough evaluation of the purpose and scope of the ICD-9-CM, Volume 3, and the AMA's Current Procedural Terminology (CPT-4), which is the basis for the HCFA Common Procedure Coding System; to evaluate the feasibility of developing a new procedure coding system to achieve the objectives of a common system; to estimate the costs, both direct and indirect, of developing and implementing a new procedure coding system or converting or adapting one of the existing systems; and to formulate a system for periodic revisions of any proposed classification system.

- In the area of procedure coding, the Subcommittee will also monitor the activities of the ICD-9-CM Coordination and Maintenance Committee, which was formed within the Department of Health and Human Services in September 1985 to identify major needs for modifications, additions, or deletions to the ICD-9-CM procedure codes.

## **Minority Health Statistics**

When the National Committee on Vital and Health Statistics (NCVHS) approved the charge to the Subcommittee on Minority Health Statistics (formerly a work group) at its February 6, 1986, meeting, the Committee directed that initial priority should be given to the following two items of the charge, with a final report on those items due by June 1987:

- Item 1—Review the cooperative efforts between the Department of Health and Human Services (DHHS) and the States directed at developing standardized Hispanic identifiers in vital statistics records.
- Item 5—Review current and planned DHHS data collection systems, assess their ability to produce data on minorities, and make appropriate recommendations.

The Subcommittee met on April 25, 1986, to hear presentations from experts concerning the process used to revise the U.S. Standard Certificates of Live Birth and Death and on the pros and cons of alternate approaches to identify Hispanics in the proposed 1989 revision of the standard certificates.

Although no item to identify events occurring to Hispanics is on the current standard certificates (implemented in 1978), the Subcommittee learned that National Center for Health Statistics (NCHS) staff have strongly encouraged States to include such an item; and, currently, 25 registration areas do identify births to Hispanic parents and 24 areas identify deaths of Hispanics. Ten areas accomplish this by asking if the persons involved are Hispanic; and, if the answer is yes, what the specific Hispanic origin or descent is. The remaining 15 areas use a general question on origin or descent.

The Panel to Evaluate the U.S. Standard Certificates established in 1983 to consider recommendations for the revised certificates included State registrars and statisticians, representatives of users of vital statistics data, and representatives of those who have responsibility for completion of the record. Subgroups were established to review each type of certificate (for example, birth, death), and a Parent Group was designated to review the recommendations from each of the subgroups and to make the final recommendations on content and format.

Input from others was sought via the mailing of approximately 6,400 questionnaires to about 1,800 persons and organizations. All recommendations received were reviewed and considered by the panel of experts.

Two criteria for items to meet in order to be included on the standard certificates were set by the panel at its first meeting. They were: (1) an item must be of demonstrable need for legal purposes or for public health or research program purposes; and (2) there must be a reasonable assumption that data on an item can be obtained with a fair amount of accuracy and completeness.

The panel recognized the need to include an item that would enable identification of vital events occurring to Hispanics. The panel felt that in order to achieve an adequate level of completeness it was necessary to have an item that a majority of States would feel comfortable adopting, both States with a large Hispanic population and States with few Hispanics.

After much discussion, the Parent Group recommended an open-ended question that asked for ancestry. The question included six prompts—the first three were Mexican, Puerto Rican, and Cuban, and the remaining prompts were at the discretion of the registration area. It also recommended that in States with a large Hispanic population (either currently having the Hispanic origin question or preferring that question) an Hispanic origin question might be substituted.

This approach was considered acceptable by most registration areas, and it permitted the identification of a number of ethnic minority groups. In addition, there was a concern that if the principal recommendation were a specific Hispanic origin question many areas would not consider the alternate ancestry question.

The following concerns about the recommendation were expressed by persons at the Subcommittee meeting:

1. Hispanics are the only minority group for which Congress has specifically mandated that DHHS and other agencies collect data. Failure to recommend the Hispanic origin question is not considered consistent with this mandate.
2. Use of the term "ancestry" has not been tested, so the reliability and validity of information obtained using that term is unknown.
3. The Hispanic origin question is most directly comparable to the U.S. Bureau of the Census decennial census enumeration, thereby providing comparability to this important source of denominator data.

4. NCHS publishes Hispanic natality data, and it will soon publish Hispanic mortality data using information obtained by asking about origin or descent. A change to asking about ancestry would result in data of unknown comparability and thereby hinder trend analyses.
5. Identification of Hispanics using a question about ancestry rather than a direct question about Hispanic origin is not acceptable to Hispanics, particularly when the underlying purpose is to identify Hispanics.
6. Coding information from an ancestry question will be considerably more complex and costly than coding information from an Hispanic origin question.

At the conclusion of the meeting, the Subcommittee members unanimously felt that the Hispanic origin question was the better way to identify Hispanics and that the Hispanic identifier should be used on the standard certificates of birth and death. For areas having small Hispanic populations, the Subcommittee recommended that the ancestry question be substituted.

The Subcommittee asked the chairperson of the panel of experts who developed the recommendations for the revised standard certificates to query members of the Parent Group to see if they would be willing to reverse the recommendation so that the preferred item would ask about Hispanic origin or descent.

The Parent Group met and considered this possibility. In their deliberations, Parent Group members expressed concern that in order to reverse the decision on ancestry, they would have to ignore their criteria for placing an item on the certificates. If this were done, several other items that were rejected based on those criteria should be reconsidered. Given this concern, and the fact that the Group had officially been disbanded, the Parent Group members elected to let the original decision stand.

At the June 6 meeting of the National Committee, the Subcommittee presented a report on its April 25 meeting along with a recommendation that the revision to the U.S. Standard Certificates of Live Birth and Death include an item to identify events to persons of Hispanic origin. The preferred item recommended would ask if individuals are of Hispanic origin; if the answer is yes, then the specific origin question would be asked. For States unable to adopt this approach, the alternative would be a general ancestry question with the first three of six parenthetical examples being Hispanic groups. The Committee accepted the recommendation of the Subcommittee and recommended that the Director, NCHS, include it in the revision of the Standard Certificates. This recommendation was followed by the NCHS, the agency responsible for development and promulgation of the standard certificates.

Having completed item 1 of its charge, the Subcommittee met on September 29, 1986, to develop a workplan for item 5. At this meeting, the Subcommittee agreed that its activities in the coming year should revolve around assessment of the Department's abilities through its data collection systems to produce information on

access to and financing of health care of minorities. The Subcommittee further agreed to review only those data systems that meet the following criteria:

1. The data system is continuous or is conducted with periodicity.
2. The data system includes a sufficiently large sample size so as potentially to be able to produce reliable estimates for different minority groups.
3. The data system is adaptable to modifications.

On October 9, the NCVHS reviewed and approved the workplan submitted by the Subcommittee for item 5 of its charge. A report containing recommendations is to be provided at the fall 1987 NCVHS meeting. Given the focus of the Subcommittee's investigation, it was asked also to consider issues relating to data on access to and financing of health care for the indigent population.

### **Data Gaps in Disease Prevention and Health Promotion**

The Subcommittee on Data Gaps in Disease Prevention and Health Promotion, which also evolved from a work group, concluded that many of the gaps that existed in data required to assess overall national progress toward the 1990 Objectives for the Nation have been closed since 1982 with new national surveys. The problem of data gaps centers now on State and local data required for assessing needs and planning and evaluating health promotion programs. Meetings have been held by individual Subcommittee members with Federal officials and national organizations (such as the Association of Schools of Public Health and the Association of State and Territorial Health Officials) attempting to address these problems.

Federal agencies with major interests and capacities to support State and local data needs, identified by the Subcommittee, include the Centers for Disease Control (CDC), National Center for Health Statistics (NCHS), National Center for Health Services Research (NCHSR), National Institute on Occupational Safety and Health (NIOSH), and Office of Disease Prevention and Health Promotion (ODPHP). For example:

- The Center for Health Promotion and Education at CDC has subsidized and provided training for State and local behavioral risk factor surveys using a common instrument and interviewing and sampling procedures.
- NCHS has cooperated with CDC in the foregoing surveys and has nurtured State and local uses of national data in a variety of ways. NCHS also works with State vital and health statistics offices or centers. The Center sponsored a seminar in Rhode Island in August to acquaint potential users with NCHS data sets, with emphasis on the 1985 National Health Interview Survey Health Promotion and Disease Prevention questionnaire.
- NCHSR held a conference in the fall of 1985 on data needs at the State level for health promotion.

- NCHS, in cooperation with the Bureau of Labor Statistics (BLS) and NIOSH, is pursuing possible uses of NCHS, NIOSH, and BLS data and other sources to measure worker injuries and occupational health.
- The ODPHP maintains the central tracking system for monitoring progress on the Objectives for the Nation. That office has discussed the possibility of modifying the system to permit States to add items peculiar to their own objectives or concerns.
- The Intergovernmental Health Policy Project at the George Washington University prepared a report for the ODPHP, "A Review of State Activities Related to the Surgeon General's Health Promotion and Disease Prevention Objectives for the Nation."

The New England Conference on Health Promotion and Illness Prevention brought out data previously unpublished and revealed problems of data incompatibilities among the New England States. Several other States have published their proceedings of conferences on long-range planning for disease prevention and health promotion. Data gaps are identified in several of these.

One Subcommittee member reported on his project in Virginia to develop a chronic disease morbidity surveillance system through primary care practitioners. This could have major implications for augmenting communicable disease reporting.

Private sector resources include health insurance companies, food distributors, and business health care coalitions interested in many forms of data pertaining to the health care costs incurred on behalf of workers.

In light of the above activities, a workplan for the coming year was proposed by the Subcommittee and accepted by the National Committee on Vital and Health Statistics at its October 1986 meeting. The workplan will focus on three areas of activity related to data gaps for health promotion and disease prevention:

1. Explore the need for an inventory of existing national data bases that could be useful at the State or local level and for a description of selected State and local data bases that have been shown to be useful.
2. Identify "considerations" for determining when to use primary data vs. model based estimates.
3. Develop and promote strategies for the use of "shared expertise."

The Subcommittee will, over the next year, develop a series of recommendations related to the three areas outlined above. Draft recommendations will be developed and presented for discussion at the public forum offered by the Prevention '87 Conference to be held in Atlanta, Ga., April 10-12, 1987. A final set of recommendations will be presented to the Committee at the June 1987 meeting.

## **Statistical Aspects of Physician Payment Systems**

The Subcommittee on Statistical Aspects of Physician Payment Systems, which began as a work group in 1984 and evolved into a subcommittee in 1985, continued its efforts to assess current and anticipated needs of users of data from the patient-physician encounter in the ambulatory care setting. During fiscal year 1986, the Subcommittee held two meetings on October 15, 1985, and January 14, 1986, to receive additional testimony from public and private insurers and researchers. Participants included representatives of the Medicare and Medicaid programs, the Department of Defense, the Veterans Administration, the Centers for Disease Control, a commercial insurer, a Blue Cross Blue Shield plan, a self-insured employer, and a health planning group.

The Subcommittee presented a major report on its findings, conclusions, and recommendations to the National Committee on Vital and Health Statistics (NCVHS) at its meeting on June 6, 1986. The report emphasized the increasing plurality of data uses and of sites of care in the ambulatory arena and underscored the value of standard definitions to facilitate comparison of different data bases across systems and to achieve as much uniformity as possible at the national level. The NCVHS approved the report and submitted it to the Assistant Secretary for Health in July 1986. Because of the considerable interest in both the public and private sectors in the issues investigated by the Subcommittee, the report was distributed by the National Center for Health Statistics in the Working Paper Series, and it is being published as an NCHS Series 4 report.

The Assistant Secretary for Health circulated the report to the Health Information Policy Council (HIPC), which he chairs, for review; and, based on the Council's comments, he responded to the Committee in November 1986. The HIPC concurred with the National Committee's recommendation to conduct a thorough and systematic review of all items of the Uniform Ambulatory Medical Care Minimum Data Set over the coming year for the purpose of developing a revised version that meets current and anticipated needs. The Council will consider establishing an interagency task force under its auspices to conduct a concurrent review of the minimum data set from the point of view of internal programmatic needs and uses.

The Subcommittee looks forward to working with the Department on this joint endeavor, and it also will provide continuing liaison with the evolving data systems related to physician services and payment.

The Executive Summary of the Subcommittee's report follows.

## Executive Summary of the Subcommittee's Report

### *Introduction*

A number of forces are currently converging to increase interest in ambulatory care data and stimulate reevaluation of the Uniform Ambulatory Medical Care Minimum Data Set. The changing patterns for delivering and financing patient care are all having an impact on the ambulatory care arena. Procedures previously performed exclusively within hospitals increasingly are now taking place on an ambulatory or outpatient basis. The technological advancements and changes in insurance coverage that have made these shifts possible have stimulated the growth of various alternate care sites, such as free-standing surgical centers and urgent centers, as well as the expansion of existing hospital outpatient services. The public and private commitment in this decade to health promotion and disease prevention has been reflected in a growing interest in primary care and self-help involving ambulatory care services. The emphasis in care for our aging population is also on independent living and ambulatory care.

The emerging interest in ambulatory care services has coincided with the growing focus on reimbursement for physician services. Current approaches being considered by the Department of Health and Human Services (DHHS) for reimbursing physician inpatient services all have implications for ambulatory care services, as well.

Recognizing the numerous statistical issues involved in current and future policy choices for delivering and reimbursing physician services, the National Committee on Vital and Health Statistics (NCVHS) formed a work group in May 1984 to gather further information and to make recommendations to the full Committee. The ultimate goals of the Work Group's inquiry were to encourage comparability and standardization; to enhance the multiple utility of data bases; to assure that data requirements by third-party payers and others were justified; and to prevent unnecessary duplications. Underlying the effort was the conviction that in times of decreasing resources, high quality statistics become increasingly important in making optimal allocation decisions. The Work Group was also aware that there would be growing pressure on the analysis of ambulatory care data and that development of standard definitions, adoption of those standards, and training in their application would be necessary first steps toward turning that data into useful information.

The Work Group formed by the full Committee met on three occasions between June and October 1984 to obtain information on current and proposed departmental data activities and to identify issues that would merit further NCVHS study and assessment. The Work Group concluded that the evolving activities related to changes in methods for physician reimbursement, particularly in the ambulatory care setting, are likely to have significant implications for specific data areas and for the comparability of data through time and across health care settings. Continuing liaison among the Health Care Financing Administration (HCFA), the National Center for Health Statistics (NCHS), and the NCVHS concerning the data systems to support these activities was considered desirable, at least until the systems have been fully defined. Therefore, the Work Group recommended to the NCVHS at its

meeting in December 1984 that a subcommittee be established to provide this liaison and that it address the following tasks as its charge:

- Determine more clearly the specific needs of users of data from patient physician encounters in the ambulatory care setting.
- Develop a schematic overview of the flow of data from various ambulatory settings into the multiple data bases.
- Define better the different sites of care in the ambulatory setting and the types of services delivered so that understanding of data requirements can be improved.

The results of these tasks were to be input into the possible review and revision of the Uniform Ambulatory Medical Care Minimum Data Set, which was developed by the NCVHS in the mid-1970's and revised in 1980 but has never been officially acted upon by DHHS.

The National Committee accepted the recommendations of the Work Group and designated a Subcommittee on Statistical Aspects of Physician Payment Systems, consisting of William R. Felts, Jr., M.D., Chairman, Professor of Medicine at George Washington University Medical Center; Theodore Allison, Vice President for Government and Industry Relations, Metropolitan Life Insurance Company; and Carmault Jackson, Jr., M.D., Medical Advisor for Baptist Memorial Hospital System in San Antonio, Texas. Staff from NCHS and HCFA were requested and assigned to work with the Subcommittee.

The Subcommittee held four meetings to receive testimony on June 19, September 10, and October 15, 1985, and January 14, 1986, in order to pursue further the Work Group goals and to address the specific tasks included in its charge. Following the extensive information received from the Medicare program during the Work Group meetings, the Subcommittee continued to be updated on Medicare activities and sought to obtain comparable information from other public and private insurers. The latter provided an overview of the ambulatory care data requirements and of the flow of data for the patient-physician encounter in their respective programs or organizations, discussed uses of data and data problems, and described any work currently underway to resolve data inadequacies and to improve data quality. Researchers and planners who use data from the patient-physician encounters also contributed to the discussions. Dr. Felts and Dr. Jackson, both of whom have had extensive involvement with provider data systems and strong affiliations with national professional organizations, offered the additional perspective of practicing physicians. A representative of the American Medical Association and other observers representing professional associations also attended the sessions.

The purpose of these meetings was to:

- Gather information related to the Subcommittee's charge.
- Anticipate changes in physician payment systems that may require collection and analysis of additional items of data.

- Examine the possible impact of these changes and additions on availability, quality, and comparability of data.
- Analyze the applications of data for trend analysis, research, and program administration.

The meetings also served to bring together interested organizations in the public and private sectors to share mutual concerns and seek common solutions.

### *General findings and conclusions*

Several themes emerged from the numerous presentations heard by the Subcommittee:

- All presenters recognized the increasing need for ambulatory care data.
- Demands on ambulatory care data systems for more extensive data elements and more comparative analyses will continue to increase. Those collecting and analyzing the data must exercise caution that the quality and context of the data merit the interpretations that are made. The community of users must assure accurate, meaningful, and responsible reporting.
- There are both many commonalities and some significant differences in the needs of data users. The data variations stem primarily from administrative requirements.
- Data currently collected by public and private insurers meet most of their current needs for reimbursement, but the data may be quite inadequate for alternative reimbursement methods. Third-party payers are interested in reviewing quality of care and in conducting relevant research. However, the basic data needed for processing and paying claims continue to govern their data requirements, and data are more limited for other uses.
- Many public programs and private insurers and their trade organizations currently are undertaking efforts to achieve greater uniformity within their own data systems.
- Presenters also supported the concept of standard definitions to facilitate comparison of different data bases across systems and to achieve as much uniformity as possible at the national level. There is particularly wide support for standardization of coding systems and definitions of units of patient care. Less support was expressed for standardized claim forms, although many data collectors and users recognize their advantages.
- The Subcommittee believes that the Part B Medicare Data System (BMAD) represents the most important step at the national level to standardize and use aggregate data on physician services for policy evaluation.
- Increasing demands of employers for data from the reimbursement systems may force greater standardization of data.

- Even as public and private insurers move toward greater use of capitation, some forms of which require considerably less data for reimbursement, management information from the encounter level will continue to be needed to assess quality, efficiency, cost, and accessibility of care.
- Although data needs for operational purposes may become more decentralized under capitation, there remain needs for data at the national level to evaluate policy options, recommend program changes, and monitor performance. In a dynamic situation such as currently exists in the health care arena, data can provide a clue as to whether specific medical interventions and reimbursement mechanisms are having a positive, negative, or neutral impact on the outcome of medical care.
- Some of the needs for policy relevant information and health services research can be met by survey data, and such survey mechanisms must be supported. Current survey data on ambulatory medical care are collected on an intermittent basis and are quite limited in their coverage of different types of outpatient facilities. Information obtained by surveys differs from that acquired in remuneration data bases and, therefore, is not redundant but complementary.
- It is timely to undertake a full review of the adequacy of the Uniform Ambulatory Medical Care Minimum Data Set. The current data set defines those items that should be entered in the records of all ambulatory health care. A revision should bring the data set into accordance with the Uniform Hospital Discharge Data Set by specifying those items that should be abstracted uniformly from existing records.

Although it was not the charge of this Subcommittee to undertake a systematic review of the Uniform Ambulatory Medical Care Minimum Data Set nor to develop a full revision, the extensive presentations received by the Subcommittee did address many of the key items in the data set. The Subcommittee's findings and conclusions related to these items follow:

- **Patient Identification**

Much of the testimony was supportive of a unique patient identifier across the health care system that would facilitate managed care and linkage of records. Subcommittee members recognize both the advisability of a unique patient identifier and the difficulty of implementation. Confidentiality and privacy concerns make this an extremely complicated issue that requires more deliberation.

- **Provider Identification**

Presentations supported the need for a unique number that distinguishes the provider from all other providers and that is the same for the provider in all settings where he may be in practice. The Subcommittee members concur with this requirement.

- **Place of Service**

Presentations before the Subcommittee frequently addressed the increasingly different settings for services that are developing in the health care system. The Subcommittee concluded that a consensus group, such as the CPT Editorial Board or the NCVHS, should evaluate the definitions currently in use for place of service and determine the extent to which standardization is feasible. Survey mechanisms, such as the NCHS National Ambulatory Medical Care Survey, should continue to be supported to address some of the research questions, with attention to more specificity of sites.

- **Diagnosis**

Presenters recognized the value of accurate recording of patient problems and diagnoses, but they reported that this information is frequently unavailable in ambulatory care reimbursement systems and often is of questionable quality where available. The Subcommittee reaffirmed the importance of capturing information on all patient problems and diagnoses requiring attention at the encounter to make judgments on medical necessity and appropriateness of services, to plan resource allocation, and to carry out other policy analyses. The members concluded that the development of guidance and instructions on collecting and coding diagnosis in the ambulatory setting should be a consensus activity and that the Federal Government, as an interested participant, should be a convener of this activity. The Subcommittee further determined that the International Classification of Diseases (ICD-9-CM) is widely used by systems coding diagnoses and should continue as the standard coding convention for this purpose. Separate information on the patient's stated reason for encounter can be useful for planning, administrative, and research purposes. The ICD should be the basis for any reason-for-encounter classification system.

- **Procedures**

Testimony reinforced the value of uniform coding of procedures and the positive impact that the HCFA Common Procedure Coding System (HCPCS) has had on standardization. The Subcommittee reaffirmed the NCVHS position that strong efforts should be made to develop a single procedure coding system for inpatient and ambulatory care in the United States. The Subcommittee further believes that HCPCS, which is a live system based on CPT-4, should be the core for a national common procedure code for physician services. Concerning coding of nonphysician services, the Subcommittee supports the considerable work carried out for HCPCS and encourages continuation of this work. Additional study on implementation of a common coding system for both physician and nonphysician services should be undertaken.

### *Summary*

The Subcommittee has addressed each aspect of its charge, as follows:

- The Subcommittee has established excellent liaison with NCHS and HCFA, as well as between the public and private sectors. In many respects, the NCVHS

seems uniquely qualified to play this role for data issues that cut across departmental programs and heavily involve the private sector.

- Through the series of meetings with representatives from the public and private sectors, the Subcommittee has made significant progress in identifying more clearly the specific needs of users of data from patient-physician encounters in the ambulatory care setting.
- Discussions with users have provided input to a schematic overview of the flow of data from various ambulatory settings into the various data bases in the fee-for-service environment. Because the data systems differ considerably depending upon the method of reimbursement, it is difficult to capture the variations in one schema. However, the diagram does help to demonstrate some of the data requirements, complexities, and interrelationships.
- Presentations by various public and private insurers have described the multiple definitions and distinctions for ambulatory sites of care. Further work is required to evaluate the definitions currently in use and to determine the extent to which standardization is feasible. The Subcommittee has recommended that this activity be carried out by a consensus group, such as the CPT Editorial Board or NCVHS, and be supplemented by survey mechanisms.
- The Subcommittee's investigation has underscored the value of a Uniform Ambulatory Medical Care Minimum Data Set. This report summarizes the Subcommittee's findings and conclusions related to specific items in the data set that were addressed by the various presentations. Because some items require further study and others were not considered, the Subcommittee recommends a thorough and systematic review of all items in the Uniform Ambulatory Medical Care Minimum Data Set for the purpose of developing a revised version that meets current needs. This review and revision process should be carried out by the NCVHS and, concurrently, by an interagency task force established within the Department. The interagency task force should also have input to the definition of sites of care. Such an approach would parallel the process used for the reexamination of the Uniform Hospital Discharge Data Set and the Long-Term Care Minimum Data Set; and it should be coordinated with these two data sets to assure comprehensiveness, minimize redundancy, and facilitate episode linkage. Attention should also be given to training in use of the data set, to other approaches for assuring data quality, and to standards for reliable and meaningful analyses.

# **Appendix I. Legislative Authority for the National Committee on Vital and Health Statistics From the Public Health Service Act**

## **Section 306 subsection (k) of Public Health Service Act**

- (1) There is established in the Office of the Secretary a committee to be known as the National Committee on Vital and Health Statistics (hereinafter in the subsection, referred to as the "Committee") which shall consist of fifteen members.
- (2) (A) The members of the Committee shall be appointed by the Secretary from among persons who have distinguished themselves in the fields of health statistics, health planning, epidemiology, and the provision of health services. Except as provided in subparagraph (B), members of the Committee shall be appointed for terms of three years.  
(B) Of the members first appointed—
  - (i) five shall be appointed for terms of one year,
  - (ii) five shall be appointed for terms of two years, and
  - (iii) five shall be appointed for terms of three years,as designated by the Secretary at the time of appointment. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term. A member may serve after the expiration of his term until his successor has taken office.
- (3) Members of the Committee shall be compensated in accordance with section 208(c).
- (4) It shall be the function of the Committee to assist and advise the Secretary—
  - (A) to delineate statistical problems bearing on health and health services which are of national or international interest;
  - (B) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;
  - (C) to determine, approve, and revise the terms, definitions, classifications, and guidelines for assessing health status and health services, their distribution and costs, for use (i) within the Department of Health and Human Services, (ii) by all programs administered or funded by the Secretary, including the Federal-State-local cooperative health statistics system referred to in subsection (e), and (iii) to the extent possible as determined by the head of the agency involved, by the Veterans' Administration, the Department of Defense, and other Federal agencies concerned with health and health services;
  - (D) with respect to the design of and approval of health statistical and health information systems concerned with the collection, processing, and tabulation of health statistics within the Department of Health and Human Services, with respect to the Cooperative Health Statistics System established under subsection (e), and with respect to the standardized means for the collection of health information and statistics to be established by the Secretary under subsection (j)(i);

- (E) to review and comment on findings and proposals developed by other organizations and agencies and to make recommendations for their adoption or implementation by local, State, national, or international agencies;
  - (F) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest; and
  - (G) to issue an annual report on the state of the Nation's health, its health services, their costs and distributions, and to make proposals for improvement of the Nation's health statistics and health information systems.
- (5) In carrying out health statistical activities under this part, the Secretary shall consult with, and seek the advice of, the Committee and other appropriate professional advisory groups.

# Appendix II. Charter



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

## CHARTER

### NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

#### PURPOSE

The Secretary is charged under Section 306 of the Public Health Service Act, as amended, 42 USC 242k, with the responsibility to collect, analyze and disseminate national statistics on vital events; the extent and nature of illness and disability of the population of the United States; the impact of illness and disability of the population on the economy of the United States, and on other aspects of the well-being of its population; environmental, social, and other health hazards; determinants of health; health resources and the supply of services by health institutions; utilization of health care; health care costs and financing; family formation, growth, and dissolution; to undertake research, demonstrations, and evaluations respecting new or improved methods for obtaining current data on the matters referred to above; to undertake epidemiological research, demonstrations, and evaluations on such matters; to provide selected technical assistance to State and local jurisdictions; to coordinate health statistical and epidemiological activities of the Department; and to engage in cooperative endeavors with other countries to foster research consultation and training programs in statistical activities.

This Committee shall provide advice, consultation, and assistance and make recommendations to the Secretary through the Assistant Secretary for Health on policies and plans in developing major national systems of health data collection in the Department, on coordination of Federal health data requirements, and on analysis over a wide range of questions relating to general health problems of the population, health care resources, the use of health care services and health care financing and expenditures. In these matters, the Committee shall consult with the Health Care Financing Administration (HCFA) and other components of the Department, other Federal entities and non-Federal organizations as appropriate.

#### AUTHORITY

42 USC 242k, Section 306 of the Public Health Service Act, as amended. The Committee is governed by provisions of Public Law 92-463 which sets forth standards for the formation and use of advisory committees.

#### FUNCTION

It shall be the function of the Committee to assist and advise the Secretary:

(A) to delineate statistical problems bearing on health and health services which are of national or international interest;

(B) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;

(C) to determine, approve and revise the terms, definitions, classifications, and guidelines for assessing health status and health services, their distribution and costs, for use: (i) within the Department of Health and Human Services; (ii) by all programs administered or funded by the Secretary; and (iii) to the extent possible as determined by the head of the agency involved, by the Veterans Administration, the Department of Defense, and other Federal agencies concerned with health and health services;

(D) with respect to the design of and approval of health statistical and health information systems concerned with collection, processing, and tabulation of health statistics within the Department of Health and Human Services, and with respect to the standardized means for the collection of health information and statistics to be established by the Secretary under subsection (j) (1);

(E) to review and comment on findings and proposals developed by other organizations and agencies and to make recommendations for their adoption or implementation by local, State, national, or international agencies;

(F) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest;

(G) in the development of a report on the state of the Nation's health, its health services, their costs and distributions, to make proposals for improvement of the Nation's health statistics and health information systems, at such intervals as may be required by the Congress;

(H) in establishing standards to assure the quality of health statistical and epidemiological data collection, processing, and analysis; and

(I) with respect to data on the effects of the environment on health.

#### STRUCTURE

The Committee shall consist of 15 members, including the Chairperson. The members of the Committee shall be appointed by the Secretary, or designee, from among persons who have distinguished themselves in the fields of health statistics, health planning, epidemiology, and the provision of health services. The Secretary, or designee, shall appoint the Chair for a one-year period, renewable at the discretion of the Secretary or designee.

Members shall be invited to serve for overlapping three-year terms. Terms of more than two years are contingent upon the renewal of the Committee by appropriate action prior to its termination. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which

his/her predecessor was appointed shall be appointed only for the remainder of such term. A member may serve after the expiration of his/her term until his/her successor has been appointed.

Subcommittees composed of members of the parent Committee may be established to provide the Committee with background study and proposals for consideration and action. The Chair shall appoint members from the parent Committee to the subcommittees and designate a Chair for each subcommittee. The Chair shall appoint ad hoc subcommittees, composed solely of members of the parent Committee, as necessary to address specific issues for consideration. The subcommittees shall make their recommendations to the parent Committee. Timely notification of the subcommittees and ad hoc subcommittees, including charges and membership, shall be made in writing to the Department Committee Management Officer by the Executive Secretary of the Committee.

Management and support services shall be provided by the National Center for Health Statistics, Office of the Assistant Secretary for Health.

#### MEETINGS

Meetings shall be held at the call of the Chair, but not less than annually, with the advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings of the subcommittees shall be held, as necessary, at the call of the respective Chair, with the advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all subcommittee meetings. All subcommittees shall report their findings to the Committee.

Meetings shall be open to the public except as determined otherwise by the Secretary; notice of all meetings shall be given to the public.

Meetings shall be conducted, and records of the proceedings kept, as required by the applicable laws and departmental regulations.

#### COMPENSATION

Members who are not full-time Federal employees shall be paid at the rate of \$100 per day, plus per diem and travel expenses in accordance with the Standard Government Travel Regulations.

#### ANNUAL COST ESTIMATE

Estimated annual cost for operating the Committee and Subcommittees, including compensation and travel expenses for members but excluding staff support, is \$88,759. Estimated annual man-years of staff support required is 1.9, at an estimated annual cost of \$62,666.

REPORTS

An annual report shall be submitted to the Secretary through the Assistant Secretary for Health, not later than December 1 of each year, which shall contain, as a minimum, a list of members and their business addresses, the Committee's functions, dates and places of meetings, and a summary of Committee activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee Management Officer.

TERMINATION DATE

The duration of the National Committee on Vital and Health Statistics is continuing, and a new charter shall be filed no later than July 23, 1988, the date of the expiration of the next two-year period following the date of the statute establishing this advisory committee, in accordance with section 14(b)(2) of Public Law 92-463.

APPROVED

July 18, 1986  
Date

Gen. Robinson M.D.  
Secretary

# Appendix III. Roster of the National Committee on Vital and Health Statistics

## Department of Health and Human Services Office of the Assistant Secretary for Health

### Roster

#### *Chairman*

Ronald G. Blankenbaker, M.D. (1987)  
Vice President for Medical Affairs  
St. Vincent Hospital  
and Health Care Center  
2001 West 86th Street  
Indianapolis, Indiana 46260

William R. Felts, Jr., M.D. (1987)  
Professor of Medicine  
George Washington Univ. Medical  
Center  
2150 Pennsylvania Ave., NW.  
Rm. 405C  
Washington, D.C. 20037

#### *Ex Officio*

Manning Feinleib, M.D., Dr.P.H.  
Director, National Center for  
Health Statistics  
3700 East-West Highway  
Hyattsville, Maryland 20782

Ms. Mary Anne Freedman (1989)  
Director, Division of Public  
Health Statistics  
Vermont Department of Health  
P.O. Box 70  
Burlington, Vermont 05402

Lawrence W. Green, Dr.P.H. (1987)  
Director, Center for Health  
Promotion Research and  
Development  
Univ. of Texas Health Science Center  
Houston, Texas 77225

#### *Executive Secretary*

Gail F. Fisher, Ph.D.  
Associate Director for Program  
Planning, Evaluation, and  
Coordination  
National Center for Health Statistics  
3700 East-West Highway  
Hyattsville, Maryland 20782

Mr. James K. Hutchison (1989)  
Chief Actuary  
The Blue Cross/Blue Shield  
Association  
676 North St. Clair Street  
Chicago, Illinois 60611

#### *Current Membership*

##### *(Date Appointment Expires)*

Elizabeth L. Barrett-Connor, M.D.  
(1987)  
Department of Community  
and Family Medicine  
School of Medicine, University of  
California at San Diego, M-007  
La Jolla, California 92093

Carmalt B. Jackson, Jr., M.D. (1987)  
Medical Advisory Services  
16902 Hidden Timber Wood  
San Antonio, Texas 78248

William H. Kirby, Jr., M.D. (1989)  
401 Walpole Court  
Timonium, Maryland 21093

George C. Myers, Ph.D. (1988)  
Center for Demographic Studies  
Duke University  
2117 Campus Drive  
Durham, North Carolina 27706

Lloyd F. Novick, M.D., M.P.H. (1988)  
Director, Center for Community  
Health  
New York State Health Department  
Governor Nelson Rockefeller  
Empire State Plaza  
Corning Tower Building, Rm. 503  
Albany, New York 12237

John D. Reid, Ph.D. (1989)  
Graduate Professor of Sociology  
Howard University  
Mailing address:  
Versailles Plaza  
2400 Queens Chapel Road, Apt. 105  
Hyattsville, Maryland 20782

William J. Scanlon, Ph.D. (1988)  
Co-Director  
Center for Health Policy Studies  
Dept. of Community/Family Medicine  
Georgetown Univ. School of  
Medicine  
2233 Wisconsin Avenue  
Washington, D.C. 20007

Fernando M. Trevino, Ph.D. (1987)  
Associate Professor  
Dept. of Preventive Medicine  
and Community Health  
Gail Borden Bldg., Rm. 202  
The Univ. of Texas Medical Branch  
Galveston, Texas 77550

Karel M. Weigel, R.R.A. (1989)  
Coordinator, Records Unit  
Dept. of Medical Statistics  
and Epidemiology  
Mayo Clinic  
200 S.W. First Street  
Rochester, Minnesota 55905

### *Members Retired During 1986*

Robert H. Barnes, M.D. (1982-1986),  
Chairman—1983-1986  
1014 East Blaine Street  
Seattle, Washington 98102

Mr. Theodore Allison (1983-1986)  
Vice President  
Government and Industry Relations  
Metropolitan Life Insurance  
Company  
One Madison Avenue  
New York, New York 10010

Mr. Walter P. Bailey (1983-1986)  
Chief, Office of Cooperative Health  
and Demography  
State Budget and Control Board  
Rempert C. Dennis Bldg., Rm. 337  
1000 Assembly Street  
Columbia, South Carolina 29201

Jerome H. Grossman, M.D.  
(1985-1988)  
Chairman and Chief Executive  
Officer  
New England Medical Center, Inc.  
Boston, Massachusetts 02111

Suzanne S. Harris, Ph.D. (1983-1986)  
Deputy Assistant Secretary for  
Food and Consumer Services  
U.S. Dept. of Agriculture  
Administration Building, 207W  
Washington, D.C. 20250

Grayson B. Miller, Jr., M.D.  
(1983-1986)  
Division of Epidemiology  
Virginia Department of Health  
109 Governor Street  
Richmond, Virginia 23219

### **Meeting Dates**

*All meetings held in Washington, D.C.*

November 7-8, 1985  
February 6-7, 1986  
June 5-6, 1986  
October 9-10, 1986

# Appendix IV. Subcommittees of the National Committee on Vital and Health Statistics

## Executive Subcommittee

### Roster

Ronald G. Blankenbaker, M.D.  
(1987), Chairman  
Vice President for Medical Affairs  
St. Vincent Hospital  
and Health Care Center  
2001 West 86th Street  
Indianapolis, Indiana 46260

William R. Felts, Jr., M.D. (1987)  
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### Staff

Gail Fisher, Ph.D., NCHS  
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### Meeting Dates

*Meetings held in Washington, D.C.*

November 8, 1985  
February 5, 1986  
June 6, 1986

*Meeting held in Portland, Maine*

August 6-8, 1986

## Functions and Process for the Executive Subcommittee, NCVHS

### *Background*

At the November 8, 1985, meeting of the National Committee on Vital and Health Statistics (NCVHS), based upon the recommendations of the Ad-hoc Subcommittee on Policy and Directions, there was established an Executive Subcommittee of the NCVHS.

### *Purpose*

The Executive Subcommittee was established to assist the Chairman of the NCVHS in administering the activities of the NCVHS to facilitate and expedite accomplishment of policies determined by the full Committee and in providing liaison with governmental and nongovernmental organizations. The functions and procedures governing the Executive Subcommittee are subject to approval and modification by the full Committee.

### *Composition*

The Chairman of the NCVHS is the Chairman of the Executive Subcommittee. Additionally, the Chairman of the NCVHS shall appoint, subject to ratification of

the full Committee, three members to the Executive Subcommittee on an annual basis, with the option of reappointment, if appropriate. When appropriate, the three members will be selected one member each from those who have 1, 2, or 3 years, respectively, remaining in their terms of appointment to the NCVHS. The NCVHS Executive Secretary, or designee, will be an ex officio member of the Executive Subcommittee.

### *Functions*

Specific responsibilities of the Executive Subcommittee are to:

- Identify and recommend issues for full Committee and subcommittee attention.
- Develop Committee agendas, with a view towards planning several agendas in advance.
- Develop annual NCVHS Report.
- Coordinate and facilitate subcommittee activities.
- Advise National Center for Health Statistics or other appropriate agency on allocation of annual NCVHS budget and on resource needs for future years.
- Conduct other business delegated to it by the full Committee.

### *Procedures and Process*

The Executive Subcommittee is empowered to act between full Committee meetings on those activities delegated to the Subcommittee; their actions are subject to ratification by the full Committee. All meetings will be published in the Federal Register, and they are held in conformance with the Federal Advisory Committee Act.

Specific activities include:

1. In interim periods between the full Committee meetings of the NCVHS, the Executive Subcommittee will monitor, through telephone calls, mail, and/or meetings, the progress of work and other activities relevant to the current approved program of the full Committee. Working with staff and subcommittee chairmen, activities will be facilitated and problems and issues identified and resolved to accomplish the planned program.
2. The Executive Subcommittee will review work plans developed by the subcommittees and make recommendations to the full Committee.
3. The Subcommittee may confer with chairmen of other subcommittees or with others to consider particular problems or issues impacting on the work of the full Committee. These may include senior personnel in the Department and other public and private agencies with interest in considerations appropriate to the responsibilities of the Committee.

4. Minutes of any meetings of the Subcommittee will be prepared and mailed to the full Committee membership and/or presented at the next full Committee meeting. If work progresses by mechanisms other than meetings, appropriate reports will be made to the full Committee membership.
5. The Chairman of the NCVHS or designee will report on the activities of the Subcommittee at each full meeting. This report will include an outline of the areas of concern of the Subcommittee and proposed plans for subsequent followup and activity.
6. In unusual events where some actions previously not approved by the Committee may be required by the NCVHS and a meeting has not been scheduled, the Subcommittee may consider alternatives and make recommendations to the full Committee by mail or telephone. With concurrence, approved actions may be taken by the Chairman or other formally appointed representatives of the Committee.
7. In the absence of the Chairman at an Executive Subcommittee or full Committee meeting, the Executive Subcommittee member with the most seniority on the NCVHS would act as Chairman.

## **Subcommittee on Uniform Minimum Health Data Sets**

### **Roster**

William J. Scanlon, Ph.D. (1988),  
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### **Meeting Dates**

*All meetings held in Washington, D.C.*

January 17, 1986  
 April 24-25, 1986  
 June 4, 1986  
 July 31-August 1, 1986

## **Charge to Subcommittee on Uniform Minimum Health Data Sets**

Since 1969, the Department has been working on the development and promulgation of uniform minimum health data sets and has made important progress, particularly in the area of the Uniform Hospital Discharge Data Set (UHDDS). The recently established Health Information Policy Council (HIPC) chaired by the Assistant Secretary for Health is, by Secretarial charter, the new focal point for these efforts within the Department. The Council has made some decisions regarding the next steps to be taken on Uniform Minimum Health Data Sets and requests the assistance and recommendations of the National Committee on Vital and Health Statistics (NCVHS) in several areas. The charge reflects the specific requests made by the HIPC.

It shall be the charge to this Subcommittee to:

1. Review and evaluate the current Uniform Hospital Discharge Data Set in light of current developments and identified problems. (This is a version approved by a former Secretary and another one published by the NCVHS.) This review is to be conducted in cooperation with an interagency task force comprised of representatives of departmental programs that would be affected by changes in the data set.
2. Identify specific problems or inadequacies in the UHDDS coverage of items, item content, and definitions. Recommend additions, deletions, and modifications to the data set.
3. Consider current trends in data collection and storage practices within the hospital and recommend ways and means of collecting and recording the UHDDS so that it is readily retrievable.
4. Prepare a written report of the review and recommendations for submission to the HIPC by September 1, 1983.
5. Review and evaluate the current Long-Term Care Minimum Data Set (LTCMDS) in terms of the findings and recommendations of the first test and in light of identified needs.  
This review is to be conducted in cooperation with an interagency task force comprised of representatives of departmental programs that would be affected by the data set.
6. Identify specific problems or inadequacies in the LTCMDS coverage of items, item content, and definitions. Recommend additions, deletions, and modifications to the data set.
7. Consider current trends in data collection and storage practices within long-term care facilities and recommend ways and means of collecting and recording the LTCMDS so that it is readily retrievable.
8. Prepare a written report of the review and recommendations for submission to the HIPC.

## Subcommittee on Disease Classification and Automated Coding of Medical Diagnoses

### Roster

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### Meeting dates

*Meeting held in Washington, D.C.*

April 2, 1986 (Working Session)

*Meeting held in Bethesda, Maryland*

December 2, 1986

## Charge to Subcommittee on Disease Classification and Automated Coding of Medical Diagnoses

The Subcommittee will continue to serve as a forum where concerns and interests can be expressed; as a liaison between the private and governmental sectors in health statistics; as a monitor of ongoing activities; and, at times, as conciliator among disputants.

It shall be the charge to this Subcommittee to monitor, evaluate, and formulate recommendations as appropriate concerning the progress in the following areas:

1. The progress toward the development of ICD-10; to review and evaluate areas where conflicting proposals emerge, and to participate in the development of recommendations that are most compatible with priority concerns in the United States.
2. The progress of international decisions regarding ICD-10 as related to needs in the United States that would require the development of an ICD-10-CM. To consider alternative mechanisms and suggested timetables if an ICD-10-CM were perceived as necessary.

3. The progress of activities moving toward the development of a single classification system for procedures in the United States to be used for physician fee-for-services, diagnostic reporting, and hospital inpatient care reimbursement that will respond to data user needs.
4. The ongoing refinement of diagnosis related groups (DRG's), case mix indexes, and severity indexes.
5. The progress in a number of related areas such as systems for automated coding of medical diagnoses, improved medical terminology and nomenclature, and quality of diagnostic data.

### **Subcommittee on Minority Health Statistics**

#### **Roster**

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#### **Meeting Dates**

*Meetings held in Washington, D.C.*

April 25, 1986  
 December 8-9, 1986

*Meeting held in Las Vegas, Nevada*

September 29, 1986  
 (Working Session)

### **Charge to Subcommittee on Minority Health Statistics**

It shall be the charge to this Subcommittee to:

1. Review the cooperative efforts between DHHS and the States directed at developing standardized Hispanic identifiers in vital statistics records.
2. Review the cooperative efforts to train personnel to complete vital statistics records accurately (particularly with regard to correct coding of causes of death and racial/ethnic identifying items).

3. Assess compliance with the Office of Federal Statistical Policy and Standards Directive Number 15 among DHHS agencies that collect health data: Where possible and desirable, further breakdown within racial and ethnic categories should be encouraged, for example, national origin of Hispanics and Asian or Pacific Islanders. Also, agencies should be encouraged to maintain specific racial and ethnic identifiers when processing original data.
4. Explore mechanisms for matching individual records from among Government data sets for health and statistical research purposes.
5. Review current and planned DHHS data collection systems, assess their ability to produce data on minorities, and make appropriate recommendations.
6. Review the efforts of ongoing research programs to incorporate appropriate research activities on minority health.
7. Report to the Committee on findings, recommendations for resolving issues and problems, and suggested courses of action.

### **Subcommittee on Data Gaps in Disease Prevention and Health Promotion**

#### **Roster**

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 Gregory Christenson, ODPHP/DHHS

#### **Meeting Dates**

*Meeting held in Kingston, Rhode Island*  
 August 25, 1986 (Working Session)

*Meeting held in Las Vegas, Nevada*  
 September 30, 1986 (Working Session)

## **Charge to Subcommittee on Data Gaps in Disease Prevention and Health Promotion**

It shall be the charge of this Subcommittee to:

1. Participate, as NCVHS representatives, in meetings of other groups to identify more currently how the Subcommittee can best use and supplement the efforts of other organizations addressing data gaps in disease prevention and health promotion.
2. Compile inventory of data sources and data items related to each of the health promotion objectives.
3. Recommend NCVHS role in supporting the development, maintenance, improvement, and quality control of data systems for health promotion.
4. Recommend other Federal action to fill gaps and to strengthen the quality of data available for policy decisions in health promotion.

## **Subcommittee on Statistical Aspects of Physician Payment Systems**

### **Roster**

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### **Staff**

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### **Meeting dates**

*All meetings held in Washington, D.C.*

October 15, 1985  
January 14, 1986  
January 15, 1986 (Working Session)  
April 2, 1986 (Working Session)

## **Charge to Subcommittee on Statistical Aspects of Physician Payment Systems**

It shall be the charge of this Subcommittee to:

1. Determine more clearly the specific needs of users of data from patient-physician encounters in the ambulatory care setting.
2. Develop a schematic overview of the flow of data from various ambulatory settings into the various data bases.
3. Define better the different sites of care in the ambulatory setting and the types of services delivered so that understanding of data requirements can be improved.

The results of these tasks will be input into the possible review of the Uniform Ambulatory Medical Care Minimum Data Set.

# Appendix V. Characteristics for Assessing Emerging Issues

## Nature of Issue

1. Statistical importance

What is the issue's importance to the collection, analysis, and dissemination of health statistics?

2. Public health importance

What public health questions are related to the issue?

3. Political implications

What are the political implications in the following areas?

- Interagency issues.
- Public-private sector issues.
- Policy uses.
- Data confidentiality.
- Data sharing.

4. Timeliness

Is the issue of high current interest?

What is the probability that the Committee's recommendations will influence Department policy at this time?

Does the issue have short-term or long-term implications for health statistics?

5. Audience

What groups are interested in the issue?

- NCVHS.
- DHHS.
- One agency within DHHS.
- Multiple agencies within DHHS.
- National interest.
- States, subnational interest.
- Private sector.

6. Appropriateness for Committee involvement

Is any other group either within or outside the Department addressing the issue?

Can another group address the issue as well or better than the NCVHS?

How would the following unique characteristics of the Committee contribute to the issue?

- Broad charter.
- Multidisciplinary membership.
- Liaison role among agencies and between public and private sectors.

7. Guidance

Has Congress, the Department, or an agency within the Department sought guidance on the issue?

## **Process Issues**

1. Manageability

Can the issue and related tasks be conceptualized?

Is it possible to collect information about the issue?

Can recommendations be produced?

2. Timing

Is there adequate time to review the issue?

If tasks are defined, how much time is required to complete them?

Will the issue require short-term or long-term Committee involvement?

3. Required activities

Which of the following activities are desirable or required?

- Monitoring.
- Information building.
- Consensus development.
- Completion of specific tasks.
- Advocacy.

4. Approach

Which of the following approaches would be most appropriate for addressing the issue?

- Current Subcommittee.
- New Subcommittee.
- Work Group.
- One member serve as agent of Committee to monitor, gather information, represent Committee in meetings.
- Policy statements.
- Recommend action by another group.
- Request briefing.

**FILE**