Performance Measurement

Preventive Care: Review of the Performance Measures by the Performance Measurement Committee of the American College of Physicians

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Introduction

The United States healthcare system has shifted its efforts to focus on priority areas of value-based care and to deliver integrated preventive care services at lower costs. In spite of these efforts, intricacies of the current system impede physician’s abilities to seamlessly embed screening protocols and preventive care interventions (1). Lack of awareness and appropriate knowledge, adherence issues beyond the physicians control, and unintended consequences of the pressures to comply with a value-based system pose barriers to quality outcomes among primary care physicians and the populations they serve (2-4).

While the impact of screening interventions on lifestyle changes is questionable, stakeholders agree that preventive care measures play a significant role in achieving measureable improvements of clinical outcomes (5). Failure to acknowledge the importance of this role needlessly endangers the health of current and future populations (6).

The American College of Physicians (ACP) Performance Measurement Committee (PMC) reviewed performance measures related to Preventive Care to assess whether the measures are evidence-based, methodologically sound, and clinically meaningful.

Methods

Between November 8, 2017 and April 13, 2018 we searched to identify relevant performance measures from the National Quality Forum (NQF), the Centers for Medicare and Medicaid Services Quality Payment Program (QPP) and the National Quality Measures Clearinghouse (NQMC) websites. The inclusion criteria were performance measures endorsed by the National Quality Forum, currently used in the Centers for Medicare and Medicaid Services’ (CMS) Value-Based Payment programs (VBP) or currently used in federal reporting programs. The PMC identified and reviewed 28 performance measures.

To determine the validity of the selected performance measures as indicators of the quality of health care provided by internal medicine physicians, reviewers used a modification of the RAND-UCLA appropriateness method. The committee chair (NF) and immediate past chair (CM) served as moderators for the panel process and did not rate the measures.

Results

Among the 28 measures* in preventive care measures list, 6 (21%) were rated as valid, 10 (36%) were rated as not valid, and 12 (43%) were rated as uncertain validity. While the measures rated as invalid represent important clinical concepts, lack of support is mainly based on methodological flaws.

*Access the full list of recommendations here
Recommendation
ACP does not support NQF #0575: “Comprehensive Diabetes Care: Hemoglobin A1c Control (<8%)” because of uncertain validity.

Rationale
ACP does not support NQF measure #0575: “Comprehensive Diabetes Care: Hemoglobin A1c Control (<8%).” This is a high impact measure that addresses an important performance gap; however, the specifications do not align with the ACP guidance statement on HbA1c targets for glycemic control. ACP recommends clinicians personalize goals for glycemic control in patients with type 2 diabetes on the basis of a discussion of benefits and harms of pharmacotherapy, patients’ preferences, patients’ general health and life expectancy, treatment burden, and costs of care. Additionally, implementation could promote overuse of treatment and concurrent hypoglycemia. Furthermore, the threshold of reaching a specific HbA1c does not take into account the individual starting points for each patient. While 8% is an appropriate HbA1c target for some patients, the performance threshold for this measure should not be 100%. Also, implementation could discourage clinicians from treating lower socioeconomic status (SES) patients. Developers should consider adding some element of risk adjustment, which would increase the utility of the measure for individual clinicians. While we support implementation of this measure to address population health concerns where large sample sizes will generate accurate results, this measure will not perform well at the individual clinician-level. The outcome relies heavily on patient adherence and while clinicians influence adherence to an extent, other factors beyond the clinicians control could unfairly penalize clinicians who treat lower SES patient populations. A more meaningful measure for individual clinicians may address appropriate management of diabetic patients with poor glycemic control.

Measure Specifications

| NQF 0575: Comprehensive Diabetes Care: Hemoglobin A1c Control (<8%) |
| Measure Steward: | National Committee for Quality Assurance |
| NQF Status: | NQF Endorsed, Last Updated Jun 10, 2016 |
| Use in Federal Program: | Qualified Health Plan, Quality Rating System |
| Description: | The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year. |
| Numerator Statement: | Patients whose most recent HbA1c level is less than 8.0% during the measurement year. |
| Denominator Statement: | Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year. |
| Exclusions: | Exclude patients who did not have a diagnosis of diabetes, in any setting, |
Type of Measure: Outcome  
Level of Analysis: Health Plan, Integrated Delivery System  
Care Setting: Outpatient Services  
Data Source: Claims, Electronic Clinical Data, Electronic Health Records, Paper Medical Records

Recommendation
ACP does not support NQF #1932: “Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)” because of uncertain validity.

Rationale
ACP does not support NQF measure #1932: Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD).” This measure represents an important clinical concept and clinicians should screen for diabetes in patients who are diagnosed with schizophrenia or bipolar disorder AND obesity and who are also prescribed antipsychotic medication therapy. However, developers do not cite a performance gap, the specifications are significantly flawed, and developers cite evidence on patients who are overweight to form the basis of the measure while this measure applies to all patients. Furthermore, the numerator should specify an evidence-based time-interval. In patients with normal results, the American Diabetes Association (ADA) recommends a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status. While implementation poses low provider-burden, usability is low without evidence for when next to screen. Also, the numerator and denominator should specify an evidence-based age range and the age cut-off seems arbitrary. The ADA recommends testing begin at age 45 years in patients who are not overweight and who do not have any risk factors for developing diabetes. Testing for prediabetes should only be considered in adolescents who are overweight. Additionally, the specifications should include exclusion criteria for patients with limited life expectancy and increased fragility. Moreover, not all antipsychotic medications are likely to cause adverse metabolic effects. Developers should consider revising the specifications to exclude medications that do not increase the risk for diabetes in patients with serious mental illness. Furthermore, the measure has not been rigorously tested. Of note, while this measure is appropriately specified to assess performance at the health plan-/integrated delivery-level analysis, developers do not cite any data to support analysis at the individual clinician-level and therefore, measure feasibility is unknown. While health-plan data may include a sufficient denominator population to generate reliable results, the denominator population may be too low in some individual/group practices to produce a stable performance estimate.
Furthermore, while health plans can easily obtain detailed clinical management data from various information systems (e.g., claims, EHRs, pharmacy), clinicians are not privy to the same information.

### Measure Specifications

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<thead>
<tr>
<th>Measure Steward:</th>
<th>National Committee for Quality Assurance</th>
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<tr>
<td>NQF Status:</td>
<td>NQF Endorsed, Last Updated Mar 09, 2017</td>
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<tr>
<td>Use in Federal Program:</td>
<td>Medicaid</td>
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**Description:** The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

**Numerator Statement:** Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

**Denominator Statement:** Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

**Exclusions:**
- Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
- Exclude patients with diabetes during the measurement year or the year prior to the measurement year.
- Exclude patients who had no antipsychotic medications dispensed during the measurement year.

**Type of Measure:** Process

**Intended Level of Attribution:** Health Plan, Integrated Delivery System, Population: Regional and State

**Care Setting:** Outpatient Services

**Data Source:** Claims, Electronic Health Data, Electronic Health Records
Recommendation
ACP does not support NQF #1934: “Diabetes Monitoring for People with Diabetes and Schizophrenia.”

Rationale
ACP does not support NQF measure #1934: “Diabetes Monitoring for People with Diabetes and Schizophrenia.” This measure targets a vulnerable population and data exist to support the benefit of screening for diabetes in patients who are diagnosed with schizophrenia AND obesity and who are also prescribed antipsychotic pharmacotherapy on improvements in clinical outcomes. However, the measure is significantly flawed. Developers should consider separating the numerator into two discrete measures: testing for HbA1c and testing for LDL. Also, the specifications should include exclusion criteria for patients who are currently prescribed statin therapy and patient refusal. Furthermore, the one-year time-frame for LDL assessment is not based on clinical evidence and therefore, implementation may promote overuse of direct LDL testing in patients without calculable LDL due to hypertriglyceridemia or in patients who are not fasting. Additionally developers cite clinical guideline recommendations based on expert from the American Heart Association/American College of Cardiology (AHA/ACC) to form the basis of the measure. AHA/ACC recommend monitoring adherence to drug therapy every 3-12 months. Furthermore, the denominator specifications should include an evidence-based age range. The United States Preventive Services Task Force (USPSTF) recommends LDL testing in men aged 35 years and older and men aged 20-35 years if they are at increased risk for coronary heart disease. The USPSTF recommends screening women aged 45 years and older if they are at increased risk of coronary heart disease and women aged 20-45 years if they are at risk for coronary heart disease. Additionally, guideline recommendations on LDL testing in patients who are prescribed statin therapy disagree. LDL testing is not indicated if the patient is currently receiving statin therapy. Some guidelines argue that clinicians need not measure LDL in patients with type II diabetes; rather, they should prescribe statins regardless of LDL results. This controversy in measurement versus treatment makes this a relatively unfair measure. It is burdensome for clinicians to re-check LDL in patients who already receive statin therapy unless the clinician is assessing for adherence to therapy. Of note, the measure is not feasible for implementation at the individual clinician level. While health plans can easily obtain detailed clinical management data from various information systems (e.g., claims, EHRs, pharmacy), clinicians are not privy to the same information. This measure is appropriately specified to assess performance of health plans covering a significant proportion of patients who are diagnosed with mental illness.

Measure Specifications

<table>
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<th>NQF 1934: Diabetes Monitoring for People with Diabetes and Schizophrenia</th>
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<tr>
<td>Measure Steward: National Committee for Quality Assurance</td>
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<tr>
<td>NQF Status: NQF Endorsed, Last Updated Jun 10, 2016</td>
</tr>
<tr>
<td>Use in Federal: Not in use</td>
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</tbody>
</table>
Program: The percentage of patients 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

Numerator Statement: One or more HbA1c tests and one or more LDL-C tests performed during the measurement year.

Denominator Statement: Patients age 18-64 years of age as of the end of the measurement year (e.g. December 31) with a schizophrenia and diabetes diagnosis.

Exclusions: Exclude patients who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Type of Measure: Process

Intended Level of Attribution: Health Plan, Integrated Delivery System

Care Setting: Outpatient Services

Data Source: Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records

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Drs. Metersky and Persell reported financial relationships with commercial entities and were recused from authorship of this paper.

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References


