Performance Measurement

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

Writing Committee

Amir Qaseem, MD, PhD, MHA; Nick Fitterman, MD (Chair); J. Thomas Cross, MD, MPH (Vice Chair); Steven M. Asch, MD, MPH; Eileen Barrett, MD, MPH; Peter Basch, MD; Robert Centor, MD; Andrew Dunn, MD, MPH; Catherine MacLean, MD, PhD; Matthew E. Nielsen, MD, MS; Robert Pendleton, MD; Sameer D. Saini, MD, MS; Paul Shekelle, MD, MPH, PhD; Sandeep Vijan, MD, MS; and Sarah J. Dinwiddie, RN, MSN on behalf of the Performance Measurement Committee of the American College of Physicians

ACP Performance Measurement Committee Members*

Nick Fitterman, MD (Chair); J. Thomas Cross, MD, MPH (Vice Chair); Steven M. Asch, MD, MPH; Eileen Barrett, MD, MPH; Peter Basch, MD; Robert Centor, MD; Andrew Dunn, MD, MPH; Eve A. Kerr, MD, MPH; Catherine MacLean, MD, PhD; Mark Metersky, MD; Matthew E. Nielsen, MD, MS; Robert Pendleton, MD; Stephen D. Persell, MD, MPH; Edmondo J. Robinson, MD, MBA; Sameer D. Saini, MD, MS; Paul Shekelle, MD, MPH, PhD; and Sandeep Vijan, MD, MS

Corresponding author:
A. Qaseem
190 N. Independence Mall West
Philadelphia, PA 19106
Email aqaseem@acponline.org

*** Individuals who served on the Performance Measurement Committee from initiation of the project until its approval**

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 supports NQF #2455: "Post-Discharge Appointment for Heart Failure Patients."

Rationale
ACP supports NQF measure #2455: "Post-Discharge Appointment for Heart Failure Patients." Patients with a principle diagnosis of heart failure should schedule a follow-up appointment post-hospitalization. This measure is appropriately specified to assess performance at the level of the facility and implementation will counteract the unintended consequences of the re-admission measures. Unlike the re-admission measures, this measure will likely decrease length of stay for patients who are appropriately readmitted for acute exacerbations of heart disease. Also, this measure will likely encourage facilities to participate with their referral base. In contrast to other care coordination measures that only require documentation of the referral to fulfill the measure requirements; this measure is appropriately specified to encourage facilities to close the referral loop. We support implementation of this measure over NQF measure #2439: "Post-Discharge Appointment for Heart Failure Patients" because this measure allows for more flexibility with scheduling the follow-up appointment. Clinicians other than physicians are permitted to manage the follow-up care and the numerator does not specify a 7-day time-frame for scheduling the follow-up appointment. While this measure is a step in the right direction towards reducing preventable readmissions, it may be ineffective as a quality measure. Programs directed at shared savings from lower utilization of hospital services might be more successful in reducing admissions than programs initiated to date (7). Also, we suggest the developers revise the specifications to include an evidence-based time-frame for scheduling follow-up appointments. Furthermore, developers should consider revising the numerator specifications to define what constitutes a "home health visit." For example, it is unclear whether a telemedicine visit meets the requirements of the numerator specifications. In addition to revising the specifications to include telemedicine as an appropriate form of home health visit, developers should also define criteria for what constitutes an appropriate visit (e.g., staffed by APP, MD, or DO; includes assessment of weight or telemonitoring, etc.).

Measure Specifications

NQF 2455: Post-Discharge Appointment for Heart Failure Patients	
Measure Steward:	American Heart Association/American Stroke Association
NQF Status:	NQF Endorsed, Last Updated Dec 11, 2015
Use in Federal Program:	Professional Certification or Recognition program, Get With the Guidelines—Heart Failure Recognition program
Description:	Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).
Numerator Statement:	Patients for whom a follow up appointment was scheduled and documented prior to discharge including either:

	- an office visit for management for heart failure with a physician OR advanced practice nurse OR physician assistant OR - a home health visit for management of heart failure
Denominator Statement:	All patients, regardless of age, discharged from an inpatient facility (i.e., hospital inpatient or observation) to ambulatory care (home/self-care) of home health care with a principle discharge diagnosis of heart failure.
Exclusions:	Denominator exclusions include: Patient was discharged to a health care facility for hospice care, to home for hospice care, or to a rehabilitation facility. Patient left against medical advice. Patient expired.
Type of Measure:	Process
Intended Level of Attribution:	Facility
Care Setting:	Inpatient/Hospital
Data Source:	Registry Data

Recommendation
ACP does not support NQF #2439: "Post-Discharge Appointment for Heart Failure Patients" because of uncertain validity.

Rationale
ACP does not support NQF measure #2439: "Post-Discharge Appointment for Heart Failure Patients." This measure is appropriately specified to assess performance at the level of the facility and implementation will counteract the unintended consequences of the re-admission measures. Unlike the re-admission measures, this measure will likely decrease length of stay for patients who are appropriately readmitted for acute exacerbations of heart disease. Also, this measure will likely encourage facilities to participate with their referral base. In contrast to other care coordination measures that only require documentation of the referral to fulfill the measure requirements; this measure is appropriately specified to encourage facilities to close the referral loop. While this measure is a step in the right direction towards reducing preventable readmissions, it may be ineffective as a quality measure. Programs directed at shared savings from lower utilization of hospital services might be more successful in reducing admissions than programs initiated to date (7). Furthermore, we note several suggestions for developers to consider when they submit the measure to NQF for re-endorsement. First, we encourage facilities to distribute referrals equally so as to avoid placing undue burden on a select number of clinicians who manage patients during the recovery period. Second, there is insufficient evidence to identify the most appropriate follow-up location (e.g., PCP office vs. HF clinics). While developers cite clinical guideline recommendations to form the basis of the

measure, the evidence on which the recommendations are based includes flawed studies that identify differences in impact depending on where the patient was seen. Without identification of an appropriate follow-up setting, implementation could promote overuse without clear benefit. Third, there is insufficient evidence to support the benefit of follow-up referrals without further intervention on improvements in clinical outcomes. Fourth, the numerator does not specify any scheduling requirements. It is unclear whether scheduling an appointment post-hospitalization satisfies the numerator requirements. If the patient schedules the follow-up appointment post-hospitalization, facilities may face challenges with obtaining detailed appointment information. Reliability results for data abstraction were fair, substantiating this concern. Fifth, successful follow-up relies on the availability of the ambulatory network. It is unfair to penalize facilities for failures in the ambulatory care network. A quality measure may be more effective if aimed at criteria for hospital admission or availability of outpatient clinics for treatment of heart failure prior to hospitalization.

Measure Specifications

NQF 2439: Post-Discharge Appointment for Heart Failure Patients	
Measure Steward:	The Joint Commission
NQF Status:	NQF Endorsed, Last Updated Oct 03, 2017
Use in Federal Program:	Public reporting, Professional certification or recognition program
Description:	Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time.
Numerator Statement:	Patients for whom a follow-up appointment for an office or home health visit for management of heart failure was scheduled within 7 days post-discharge and documented including location, date, and time.
Denominator Statement:	All heart failure patients discharged from a hospital inpatient setting to home or home care.
Exclusions:	Excluded Populations: • Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay (ICD-10-PCS procedure code for LVAD and heart transplant as defined in Appendix A, Table 2.2) • Patients less than 18 years of age • Patient who have a Length of Stay greater than 120 days • Patients with Comfort Measures Only documented • Patients enrolled in a Clinical Trial • Patients discharged to locations other than home, home care, or law enforcement • Patients with a documented Reason for No Post-Discharge Appointment Within 7 Days

	• Patients who left against medical advice (AMA)
Type of Measure:	Process
Intended Level of Attribution:	Facility
Care Setting:	Inpatient/Hospital
Data Source:	Electronic Health Records, Paper Medical Records

Financial Statement: Financial support for the Performance Measurement Committee comes exclusively from the ACP operating budget.

Disclosure of Interests and Management of Conflicts:
At each meeting and conference call, ACP staff and PMC committee members declared all financial and intellectual interests relevant to health or healthcare. A record of disclosures of interest is kept for each Performance Measurement Committee meeting and conference call and can be viewed at https://www.acponline.org/about-acp/who-we-are/leadership/committees-boards-councils/performance-measurement-committee/performance-measurement-committee-disclosures-of-interest.

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

APPROVED BY THE ACP BOARD OF REGENTS ON:
July 21, 2018

Members of the PMC:
Individuals who served on the Performance Measurement Committee from initiation of the project until its approval:

†Steven M. Asch, MD, MPH, FACP
†Eileen D. Barrett, MD, MPH, FACP
†Peter Basch, MD, MPH, MACP
†Robert Centor, MD, MACP
†J. Thomas Cross, Jr., MD, MPH, FACP
†Andrew Dunn, MD, MPH, FACP
†Nick Fitterman, MD, FACP
*Eve Askanas Kerr, MD, MPH, FACP
†Catherine MacLean, MD, PhD, FACP
*Mark Metersky, MD, FACP
†Matthew E. Nielsen, MD, MS
†Robert Pendleton, MD, FACP

*Stephen D. Persell, MD, MPH, FACP
*Edmondo J. Robinson, MD, MBA, FACP
†Sameer Saini, MD, MS
†Paul Shekelle, MD, MPH, PhD, FACP
†Sandeep Vijan, MD, MS

†Author (participated in discussion and voting).
*Non-author contributor (participated in discussion but excluded from voting).

Requests and inquiries: Amir Qaseem, MD, PhD, MHA, FACP, American College of Physicians, 190. N Independence Mall West, Philadelphia, PA 19106: email, aqaseem@acponline.org

References

1. Agerwala SM, McCance-Katz EF. Integrating Screening, Brief Intervention, and Referral to Treatment (SBIRT) into Clinical Practic Settings: A Brief Review. Journal of Psychoactive Drugs. 2012;44(4): 307-317. doi:10.1080/02791072.2012.720169

2. Chou WC, Tinetti ME, King MB, Irwin K, Fortinsky RH**.** Perceptions of physicians on the barriers and facilitators to integrating fall risk evaluation and management into practice. J Gen Intern Med. 2006;21:117-22.

3. Fortinsky RH, Iannuzzi-Suchich M, Baker DI, et al. Fall-risk assessment and management in clinical practice: views from healthcare providers. J Am Geriatr Soc. 2004;52(1522-1526).

4. U.S. Census Bureau. Interim Projections By Age, Sex, Race, and Hispanic Origin: 2000–2050. In: U.S. Census Bureau PD, ed. Suitland, MD; 2004.

5. Van Schayck OC, Pinnock H, Ostrem A, Litt J, Tomlins R, Williams S, et al**.** IPCRG Consensus statement: tackling the smoking epidemic – practical guidance for primary care. Prim Care Respir J. 2008;17(3):185-93.

6. World Health Organization**.** Preventing chronic diseases: a vital investment: WHO global report. 1.Chronic disease – therapy 2.Investments 3.Evidence-based medicine 4.Public policy 5.Intersectoral cooperation I. 2005.

7. Epstein AM, Jha AK, Orav EJ**.** The Relationship between Hospital Admission Rates and Rehospitalizations. New England Journal of Medicine. 2011;365(24):2287-95.

8. IDSA Sepsis Task Force**.** Infectious Diseases Society of America (IDSA) POSITION STATEMENT: Why IDSA Did Not Endorse the Surviving Sepsis Campaign Guidelines. Clinical Infectious Diseases. 2018;66(10):1631-5.