

ProHealth Physicians Feedback on Draft SIM Quality Council Provisional Measure Set: Core Quality Measures

| # | Proposed Core Measure | ProHealth Physicians Feedback |
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| 1 | PCMH – CAHPS measure | While ProHealth is currently a PCMH, the organization is seriously debating whether it will pursue renewal when the current recognition expires in mid-2017. Even if ProHealth does pursue PCMH next year, as a Medicare Accountable Care Organization, we use the CAHPS surveys that required of participants in the Medicare Shared Savings program, which is not one and the same as the PCMH-CAHPS version. There is additional cost and inefficiency in managing the distribution of different surveys to patients for different programs; ProHealth does not intend to use the PCMH CAHPS tool even if it does move forward w/PCMH renewal. |
| 2 | Plan all-cause readmission | This is a standard metric across commercial and Medicare plans, both MSSP and Medicare Advantage |
| 3 | Emergency room utilization per 1,000 | This is a standard metric across commercial and Medicare plans, both MSSP and Medicare Advantage |
| 4 | Annual monitoring for persistent medications | This has become a standard metric for patients >65 but less prevalent for the younger population |
| 5 | Breast cancer screening | This is a standard metric across commercial and Medicare plans, both MSSP and Medicare Advantage |
| 6 | Cervical cancer screening | PCPs are typically frustrated by this metric in that most gynecological care is performed by the gynecologist. |
| 7 | Chlamydia screening | This is a very controversial measure for PCP for two key reasons: similar to the cervical cancer screening, the chlamydia screenings are being performed outside the primary care office. Secondly, the HEDIS definition makes this measure difficult to track. There are nuances around how they define an eligible population (i.e., use of birth control as an indication that the patient is sexually active) that raise concern about documentation and whether the patient will provide a truthful response. |
| 8 | Colorectal cancer screening | This is a standard metric across commercial and Medicare plans, both MSSP and Medicare Advantage |
| 9 | Adolescent female immunizations for HPV | This metric went to our Clinical Council for consideration in 2015 and was unanimously voted down. Concerns include minimum age and parental influence |
| 10 | Weight assessment and counseling for nutrition and physical activity for children and adolescents | This would be much better accepted if there was reimbursement for nutritional consults and follow-up visits. Difficult to document in a manner that can be easily exported for reporting. If it was a billable service, the CPT code could be used to track activity. |
| 11 | Preventative care and screening: BMI and follow-up | This is a standard Medicare Shared Savings metric; increasing presence in commercial arrangements. |

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| 12 | Developmental screening in first 3 years in life | Needs to be clearly defined – what instrument/tool is acceptable, how is this tracked, is there clear billing guidance? Health plans often have very different policies on this and sometimes the codes that they recommend are contrary to guidance from the AAP. |
| 18 | Behavioral health screening | Similar to developmental screening, the instrument/tool and billing codes must be clear and standardized across payors. |
| 19 | Medication mgmt. for people with asthma | This is a standard metric in commercial populations, primarily pediatric patients. |
| 20 | Asthma medication ratio | This will be a tough sell. In my experience, providers are agreeable to being held accountable for what they prescribe; but are extremely hesitant to be evaluated on whether the patient adheres to the prescribed regimen. |
| 21 | Diabetes A1c control (>9%) | This is a standard metric across commercial and Medicare plans, both MSSP and Medicare Advantage. However, it is critical that the health plans be able to supplement claims data with the lab values they might receive from providers' charts. Reporting from the EHR sounds easy but it's actually very complicated to pull the data and transfer it to the receiving party in a standardized electronic manner. I would suspect that small practices will have a difficult time with this. |
| 22 | Diabetes A1c testing | This is a standard metric across commercial and Medicare plans, both MSSP and Medicare Advantage. |
| 23 | Diabetes eye exam | See A1c control above in item 21. Same concerns. This is one of the more controversial measures: patients don't want to go to an eye doctor, ophthalmologists don't send reports, significant staff time and expense to tracking down results. |
| 24 | Diabetes medical attn. for nephropathy | This is a standard metric across commercial and Medicare plans, both MSSP and Medicare Advantage |
| 25 | Hypertension: controlling high BP | This is a standard metric across commercial and Medicare plans, both MSSP and Medicare Advantage |
| 26 | Use of imaging studies for low back pain | This is popular among commercial plans but frustrating to PCPs who are not typically the ones ordering the imaging. Our providers think the onus for evaluating the appropriateness should be placed on the health plan or radiologist. |
| 27 | Avoidance of antibiotic treatment in adults w/acute bronchitis | Another popular commercial metric that is difficult to truly evaluate based on claims data. There are other considerations that might influence whether an antibiotic is prescribed and those nuances can't be captured in claims. |
| 28 | Appropriate treatment for children w/URI | See #27. Claims do not tell the whole story. |

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| 29 | Follow-up care for children prescribed ADHD medication | We have this as an internal metric now but we did get a lot of pushback from PCPs who were not writing the ADHD scripts (ADHD specialists, psychiatrists, etc.) The concern is that if a child is seeing a specialist for their medications/counseling, there is no incremental value to coming in for a PCP visit (additional copay). We had to change our metric accordingly. |
| 30 | Adolescent on antipsychotics | Not sure what custom measure means but if it applies to PCPs, I can imagine that the pushback would be even more significant if the PCP is not writing the antipsychotic prescription. |
| 31 | Depression remission at 12 months | We reported on this for the 1 st time in 2015 and the results taught us an important lesson about how this is calculated. The denominator ends up being very small so you either do really well or terrible. This is the result of the appropriateness of doing another depression screening to document the PHQ score when the patient has already been diagnosed as depressed. It is counterintuitive to do follow-up “screenings” based on a confirmed diagnosis. |
| 32 | Suicide risk assessment | See #12 and 13 |
| 33 | Unhealthy alcohol use | See #12, 13, 32 |

With respect to the reporting measures, these are not commonly seen in payor arrangements. The two exceptions would be:

- % PCPs that meet Meaningful Use
- Well-child visits in ages 3-6

It would be very difficult to get consensus on the other preventive, acute/chronic, and behavioral health measures unless they were limited to specific specialties (i.e. cardiology, behavioral health providers). PCP buy-in is unlikely.

The development measures, with the exception of the unplanned admissions, are also non-standard. Almost all are based on claims and the ones that are based on EHR would be subject to a lot of scrutiny given their clinical focus. I’m not sure you’d find a group willing to report patient names for these acute and chronic conditions. Diabetic foot exams would be fine.

Overall, even with just the 33 core measures, it will be a lot for providers to absorb, especially if they are new to the value-based environment and have limited infrastructure to be able to identify and manage so much at once. Most of the commercial plans limit the # of metrics to 10-20. MSSP has 33 metrics and our providers firmly believe that is too many at one time. Consistency with the standard metrics is the key to engaging providers; raising the bar too high too quickly will cause providers to feel the “ask” is impossible and disengage altogether.