NATIONAL QUALITY FORUM
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Meeting Summary

Primary Care and Chronic Illness Standing Committee – Measure Evaluation Web Meeting

The National Quality Forum (NQF) convened the Primary Care and Chronic Illness Standing Committee for a web meeting on July 8, 2021, to evaluate one measure.

Welcome, Introductions, and Review of Meeting Objectives

NQF welcomed the Standing Committee and participants to the web meeting. NQF staff reviewed the meeting objectives. The Standing Committee members each introduced themselves and disclosed any conflicts of interest. No Standing Committee members disclosed a conflict of interest for the measure under review this cycle.

Some Standing Committee members were unable to attend the entire meeting due to early departures and late arrivals. The vote totals reflect members present and eligible to vote. Quorum was met at the beginning of the meeting but not maintained throughout the entire meeting. Therefore, the Standing Committee discussed all relevant criteria and voted on NQF #3617 *Measuring the Value-Functions of Primary Care: Provider Level Continuity of Care Measure (American Board of Family Medicine [ABFM])* after the meeting concluded using Survey Monkey to vote offline.

Topic Area Introduction and Overview of Evaluation Process

NQF staff provided an overview of the topic area and the current NQF portfolio of endorsed measures. There are currently 30 measures in the Primary Care and Chronic Illness portfolio. Additionally, NQF reviewed the Consensus Development Process (CDP) and the measure evaluation criteria.

Measure Evaluation

During the meeting, the Primary Care and Chronic Illness Standing Committee evaluated one new measure for endorsement consideration. The summary of the Standing Committee's deliberations below will also be provided in the draft technical report. NQF will post the draft technical report on August 19, 2021, for public comment on the NQF website. The draft technical report will be posted for 30 calendar days.

Rating Scale: H – High; M – Medium; L – Low; I – Insufficient; NA – Not Applicable

NQF #3617 Measuring the Value-Functions of Primary Care: Provider Level Continuity of Care Measure (ABFM)

Measure Steward/Developer Representatives at the Meeting

- Denise Paveltic
- Jill Schuemaker
- Minling Dai
- Craig Solid
- Bob Phillips

Standing Committee Votes

- **Evidence**: H-0; M-11; L-6; I-0 (11/17 – 64 percent, Pass)
- **Performance Gap**: H-0; M-13; L-3; I-0 (13/16 – 81 percent, Pass)
- **Reliability**: H-2; M-12; L-4; I-0 (14/18 – 77 percent, Pass)
- **Validity**: H-2; M-9; L-6; I-0 (11/17 – 64 percent, Pass)
- **Feasibility**: H-3; M-10; L-4; I-0 (13/17 – 76 percent, Pass)
- **Use**: Pass-15; No Pass-2 (15/17 – 88 percent, Pass)
- **Usability**: H-2; M-10; L-4; I-1 (12/17 – 70 percent, Pass)

Standing Committee Recommendation for Endorsement: Yes-13; No-4

This clinician-level measure was a newly submitted measure for endorsement. It is publicly reported nationally in the Quality Payment Program's (QPP) Merit-Based Incentive Payment System (MIPS).

The Standing Committee noted that the developer provided seven studies published between 2007 and 2019. The Standing Committee also noted that only two studies were conducted in the United States (U.S.), and both studies were focused on the Medicare population, which was a fraction of the population included in the measure. The developer noted that several U.S.-based studies with broader populations existed; although they were not included in the submission, these studies could still be provided for additional support. The Standing Committee stated it was unclear whether tracking continuity of care would result in better outcomes. The developer noted that a number of studies show that measuring continuity of care can enable change, which would ultimately improve outcomes. The Standing Committee questioned whether the studies quoted in the measure submission included all patients or only patients with chronic illnesses. The developer clarified that the studies included both groups. The Standing Committee also expressed concerns with the structure of the measure, which prioritized continuity of care over access and patient convenience. According to the developer, there was evidence showing that continuity of care should be complementary to patient choice; the developer also highlighted another study showing that continuity of care does not necessarily impede access. The Standing Committee agreed there was evidence to support the measure.

The Standing Committee noted the mean performance of 0.2763 with a standard deviation of 0.3058 based on Optum claims data, which indicated low performance. The Standing Committee noted that disparities in care data were not included; nonetheless, literature addressing disparities in care was addressed. The Standing Committee agreed that the performance gap warrants a national performance measure. The Standing Committee also noted the focus of the measure: primary care physicians (PCPs); however, primary care is often team based. A patient may see a different physician, nurse practitioner, or physician's assistant at the same practice. The Standing Committee requested more information on how team-based care would be accounted for and whether the patient seeing another member of the team at the same practice would count against the primary physician. The Standing Committee also questioned whether teaching hospitals would be at a disadvantage due to the use of residents to provide care. The developer acknowledged that many PCPs utilize a team-based approach but reassured the Standing Committee that it would not count against the physician. The developer further clarified that the data are pulled using claims data. Therefore, while the measure does focus on PCPs, it could be easily altered to review a broader group if a practice wanted to use the measure for internal improvement purposes. The developer added that many teaching hospitals were able to code using the resident's information, and the use of residents should not affect/have an impact on the measure.

The Standing Committee noted that reliability testing was conducted at the performance score level using a beta-binomial model to determine signal to noise; they also highlighted that as the sample size

increased, the reliability scores improved, which suggested that the low reliability values may be a function of small sample sizes as opposed to the inherent reliability of the measure itself.

The Standing Committee noted that validity testing was conducted at the measure score level using empirical validity testing. The Standing Committee expressed concern that clinicians with a small number of patients might be penalized because they do not see patients frequently. The developer stated that 12 months was chosen due to public reporting criteria but that practices can extend the window of measurement for quality improvement.

The Standing Committee noted that the measure's data elements are generated or collected by and used by healthcare personnel during the provision of care, and all data elements are in defined fields in electronic clinical data sets.

The Standing Committee noted the measure was approved for use in the Centers for Medicare & Medicaid Services' (CMS) MIPS program and has been used in the PRIME Qualified Clinical Data Registry (QCDR) since the 2018 measurement period. The Standing Committee stated that users of the measure were able to provide feedback and noted that the developer received mostly positive feedback. The Standing Committee also noted that the developer reported a recent update to the measure specifications, and current data cannot be used to compare performance over time.

Public Comment

No public or NQF member comments were provided during the measure evaluation meeting.

Next Steps

NQF will post the draft technical report on August 19, 2021, for public comment for 30 calendar days. The continuous public commenting period with member support will close on September 17, 2021. NQF will reconvene the Standing Committee for the post-comment web meeting on October 19, 2021.