ACP Additional Comments on CBE #4290, "Measuring the Value-Functions of Primary Care: Comprehensiveness of Care."

Importance

ACP is skeptical that implementation of the measure will lead to measurable and meaningful improvements in clinical outcomes.

Comprehensiveness is an important concept, and one of Starfield's four core pillars (4C's) included in her primary care framework. Comprehensiveness refers to "Offering a comprehensive scope of services…by building teams of professionals including [general practitioners (GPs)], registered nurses and allied health professionals that are based in the primary care space. Primary care teams can reduce the need for specialist referrals and services particularly when specialty services are made accessible at the primary care level."

Attribution at the physician level is counter to the spirit of a team-based approach to addressing comprehensive care at the practice level. This measure could be useful as a tool to assess the degree to which primary care practices within a system can address the needs of its population.

Appropriate Use

CBE #4290 evaluates quality by assessing the provision of services regardless of whether the services are appropriate. As a result, it may encourage overuse.

Clinical Evidence Base

While no guidelines support the measure, evidence from scoping and narrative reviews is cited that demonstrates a linkage of comprehensive care to desired outcomes.

The evidence supporting the selection of these 39 services and associated weighing is thin. The services and procedures included are within the scope of training and credentialing of a family medicine physician. Individual physician privileges may vary by physician preference and practice location.

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A technical expert panel (TEP) advised on the final list of services included in the measure and the weighting of services. The TEP was comprised of family physicians and family medicine researchers with almost no representation from other primary care specialties. The TEP was not inclusive of other primary care physicians for whom the measure is intended. Without having representation from internal medicine, pediatrics, or geriatrics, the definition of comprehensiveness does not consider the perspectives of these important stakeholders who provide a significant percentage of primary care in the United States. This likely influenced the measure's perspective and relevance for broader primary care practice.

Specifications

Face Validity: ACP's perspective

CBE #4290 does not evaluate quality. It attempts to measure comprehensiveness of care by calculating the number of services provided. A higher score results from an individual billing each of the 39 specified services at least once during the measured period, regardless of whether the service was warranted or could have been better or more safely performed by another clinician and/or in a different setting. As a result, the measure results cannot distinguish good from poor quality. The measure has limited applicability to other primary care physicians, as noted above. Does a geriatrician who provides 8 services provide lesser quality than a family physician who provides 25 services, particularly when the geriatrician does not offer several of the listed services (e.g., newborn care, prenatal care)?

The weights of the various services are questionable. Several of the procedure-based services have higher weights than the care-based ones. Pap smears and cervical cancer screening have the highest weight across all services. Joint and tendon aspirations are weighted higher than chronic disease management.

The measure demonstrates poor content validity due to:

- Lack of correlation between measurement expectations and practice reality
- Systematic bias against economically constrained practice environments
- Inadequate consideration of patient preference and market dynamics
- Failure to account for structural barriers to service delivery

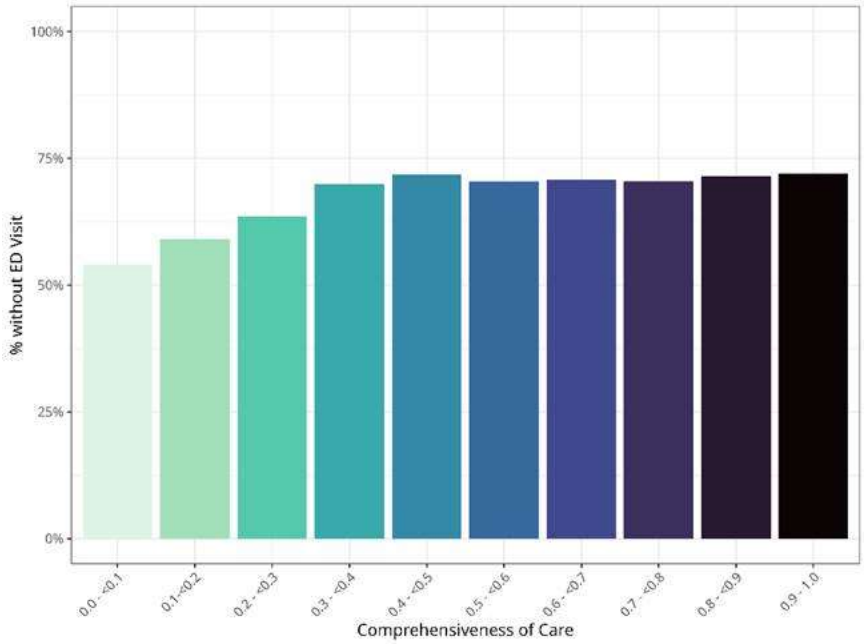
CBE #4290 risks exacerbating healthcare disparities. Medicaid-insured patients face 28% fewer preventive services than privately insured counterparts. Rural providers, who comprise 12% of the primary care workforce, report 45% fewer resources for reproductive health services due to funding gaps and community norms. Penalizing these providers for systemic failures will deepen access issues.

Face Validity: Developer's data

The developers state that they surveyed 26 primary care physicians who participate in the PRIME registry and represent physicians across the United States. 80.77% of physicians surveyed agreed that scores obtained from the measure can be used to distinguish good quality of care from poor quality. The specialty of survey respondents is not known from the information provided. The developers should clarify the proportion of the surveyed physicians in specialties other than family medicine, if any.

Empiric Validity:

The measure developers performed additional validity testing by associating the physician-specific comprehensiveness of care index with no emergency department (ED) visits vs. any ED visits as a patient-level outcome, using descriptive analysis and multivariable hierarchical logistic regression. For the descriptive analysis, they separated the comprehensiveness of the care index by deciles and reported the proportion of patients with any ED visit vs. no ED visits for 2018-2019. They conclude that there is "a definitive decrease in the ED visit rates as the comprehensiveness of care increases." However, their data do not support that conclusion (see graph below). Rather, their data suggest that a comprehensive score < 0.5 is associated with a higher ED visit rate and that further increases in comprehensiveness is not associated with further reductions in ED visits.



Measure Feasibility and Applicability

CBE #4290 is not applicable to internal medicine physicians and has potential to lead to unintended consequences.

Appointment wait times for primary care physicians have increased 48% since 2004. To meet preventive care benchmarks alone, primary care physicians would need 26.7 hours daily, a logistical impossibility that risks clinic closures. Office-based procedures reimburse $34 below break-even costs, forcing providers to subsidize care. Compounding this, 78% of substance use treatment plans require specialized credentialing, which 67% of rural practices lack due to funding constraints. Additionally, the psychological burden is enormous. Subconsciously or even consciously, knowing that one will be "measured" on how many of these services are provided to patients can have a corrosive effect on the psyche of primary care physicians and the care they provide.

CBE #4290 overlooks patient autonomy and does not account for patient preference. Surveys indicate that 72% of patients prefer gynecological care from specialists over primary care physicians, even when primary care physicians are trained equivalently. Similarly, 60.3% of women in a large HMO study opted for OB/GYNs for basic services, citing comfort and perceived expertise. While integrated behavioral health is favored by 41% of patients, barriers like stigma and fragmented insurance coverage persist.