Reviewer's report

Title: Inclusion of Short-term Care Patients Affects the Perceived Performance of Specialists: A retrospective cohort study

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Reviewer: Alex HS Sox-Harris

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This is an interesting paper on a tricky problem. When evaluating a quality measure, it is important to know how the quality measure is going to be used. The specifications of a quality measure can be perfectly valid for one purpose but not another. In this case, the authors seem motivated to address the problem that, under current measure specifications and public reporting, specialist have lower performance scores than primary care providers. So the implied use is the comparison of providers across specialties within the same institution. This highlights two issues. First, it raises the problem of partitioning credit (or blame) for patients treated in an integrated health care system. Provider-level quality measures often don’t make sense when patients are treated by many providers.

Second and more importantly, patients who are treated in PC only, treated in both PC and specialty care, and treated in specialty care only are fundamentally different patients. Further, as shown in Tables 2 and 3, the patients in both PC and specialty care for less than 90 days are very different from those who are treated longer and more consistently. The short-term patients live far away, for example. So these patients have major access problems, are probably sicker (referred to specialty care) and not surprisingly have poorer biological outcomes. Specialists treat a higher proportion of these patients than PC providers, thus making their performance look worse when this difference is driven by the characteristics of their patients rather than factors within their control.

The authors are basically arguing to case mix adjust these quality measures. The problem is that the actual specifications are a mix of outcome and process measures, and case mix adjusting quality measures in general and process measures in particular is controversial. The authors are saying that they compare favorably to PC if you don’t hold them accountable for the sicker patients from out of state. Rather than omitting these patients from the quality monitoring system, perhaps the measures should only be used to compare between specialists (and perhaps only within this institution which has a lot of out of state patients). The measures might be fine for these comparisons. However, public reporting encourages inappropriate use of the measures as currently defined. The authors suggest changing the measure so the PC-specialty care comparison is more valid but at the expense of excluding patients. Other solutions would be to rename the measures to encourage within setting comparisons. Another solution change the level of measurement to the institution rather than the provider or clinic. Another solution would be to not publically report the measure
for both settings, and use on only for internal QI purposes. I’d like the authors to consider and some of these implications.

I had some small quibbles with some of the statements:
In the abstract: Patients with short-term care had significantly lower “performance” – It is not the patients whose performance is measures.
“When comparing metrics across providers, measurement definitions become important, particularly for outcome measures” - this is true for process measures as well.
“Outcomes measured during a short-term care episode represent care provided prior to the measurement and not care received at the time of the specialist visit.” - this is confusing
Methods: On line 134, the number of patients in the sample are given, but these are more properly reported in the results section.

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
'I declare that I have no competing interests'