AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

THE AMERICAN GERIATRICS SOCIETY
40 FULTON STREET, SUITE 809
NEW YORK, NEW YORK 10038
212.308.1414 TEL
www.americangeriatrics.org

February 13, 2025

SUBMITTED ELECTRONICALLY VIA
qisupport@ahrq.hhs.gov

Re: Request for Information Regarding Diagnostic Excellence Measurement

Dear Agency for Healthcare Research and Quality (AHRQ) Quality Indicators Support Team:

The American Geriatrics Society (AGS) appreciates the opportunity to submit comments to the Agency for Healthcare Research and Quality (AHRQ) Request for Information (RFI) on the development of measures of diagnostic excellence to identify potential opportunities to improve the diagnostic process at a health system or geographic level.

AGS is a nationwide, not-for-profit society of geriatrics healthcare professionals dedicated to improving the health, independence, and quality of life of older people. Our 6000+ members include geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician assistants, pharmacists, internists, and others who are pioneers in advanced-illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. We provide leadership to healthcare professionals, policymakers, and the public by implementing and advocating for programs in clinical care, research, professional and public education, and public policy.

The AGS future vision is a society where we all are supported by and able to contribute to communities where ageism, ableism, classism, homophobia, racism, sexism, xenophobia, and other forms of bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their caregivers. We believe discriminatory policies—especially when they are perpetuated across the healthspan and lifespan—can have a negative impact on public health for us all as we age.

We appreciate AHRQ's efforts to engage with stakeholders to ensure measure development is informed by the American public as well as experts in quality measurement in order to have new and additional measures for diagnostic excellence that are applicable for the whole of our population in an inclusive manner. Below, we offer our feedback for consideration in assuring the proposed measures best address the unique healthcare needs of older adults and reflects the quality metrics that we believe are most appropriate for diagnostic excellence for all of us as we age.

RECOMMENDATIONS

Measure Name:	Closing the loop on completion of follow-up recommendations for actionable incidental findings of pulmonary nodules
Supporting Rationale:	Geriatrics health professionals care for older adults, many of whom are living with complicated medical issues and social challenge, and focus on the 5Ms of geriatrics:

	Multimorbidity, What **M**atters, **M**edication, **M**entation, and **M**obility.[1] Multimorbidity describes the older person who has more complex needs often due to multiple chronic conditions, frailty, and/or complex psychosocial needs. What Matters, Medication, Mentation, and Mobility describe the four main areas where geriatrics health professionals focus their clinical attention and form the basis for the age-friendly health systems framework that is focused on ensuring that all older people have access to this type of coordinated care, while also making sure personal needs, values, and preferences are at the heart of that care.[2] While AGS recognizes that follow-up assessments are an important part of good care when appropriate, we are concerned that this measure as written does not account for instances where follow-up imaging does not align with the patient's goals of care. This may be the case for some older adults given the increased prevalence of frailty and advanced disease or conditions (e.g., dementia) in the older population as well as life expectancy. Furthermore, we believe this type of measure carries the risk of having certain older adults subject to additional, unnecessary, and/or unwanted follow-up imaging. In order to meet the unique and complex needs of the growing population of older people—especially for those with multiple chronic conditions—care planning and coordination across the spectrum that is based on best evidence, patient preferences and care goals, life expectancy, comorbid conditions, and/or functional status is crucial. If the *Closing the loop on completion of follow-up recommendations for actionable incidental findings of pulmonary nodules* measure is finalized, AGS recommends adding an exclusion for patients whose goals of care do not align with receiving follow-up imaging for pulmonary nodules.

Measure Name:	Diagnostic Delay of Venous Thromboembolism (DOVE) in Primary Care
Supporting Rationale:	AGS supports the goal of timely diagnosis of venous thromboembolism. However, we are concerned that the *DOVE in Primary Care* measure as currently constructed may encourage a significant number of additional workups (i.e., D-dimer test, lower extremity ultrasonography) for low-risk patients. We believe this measure may be improved with the support of a supplementary balancing measure that examines the rates of positivity of common venous thromboembolism tests, such as the D-dimer test and lower extremity ultrasonography, in order to incentivize clinicians to have a high-index of suspicion for venous thromboembolism without indiscriminately ordering tests with significant low yield. If the *DOVE in Primary Care* measure is finalized, AGS recommends that AHRQ add a supporting measure for positive rates of common venous thromboembolism tests.

[1] Adapted by the American Geriatrics Society (AGS) with permission from "The public launch of the Geriatric 5Ms" [on-line] by F. Molnar and available from the Canadian Geriatrics Society (CGS) at https://thecanadiangeriatricssociety.wildapricot.org/Geriatric5Ms/. Accessed February 11, 2025.

[2] Institute for Healthcare Improvement. Age-Friendly Health Systems: Measures Guide. July 2020. Accessed February 11, 2025. https://www.ihi.org/sites/default/files/2023-09/IHIAgeFriendlyHealthSystems_MeasuresGuide.pdf

Measure Name:	Measuring the Value Functions of Primary Care: Physician-Level Continuity of Care Measures
Supporting Rationale:	AGS believes that a high-quality, cost-effective healthcare system results from care that is person-centered, team-based, and grounded in strong primary care, which includes continuity of care. While we appreciate the value of care continuity in primary care, this measure would counter efforts to focus on team-based care and embrace a team-based approach which is critically important for older complex patients who need and would benefit from such interdisciplinary care. The measure may generate seemingly lower scores for older patients who receive care in academic or team-based care settings though the quality of care provided is not lower. It may also be biased against physicians who care for complex patients that are more likely to have acute issues. AGS recommends that acute care visits are excluded or adjusted if the *Measuring the Value Functions of Primary Care: Physician-Level Continuity of Care Measures* is finalized.

Measure Name:	Stroke Symptom-Disease Pair Analysis of Diagnostic Error (SPADE) measure (Avoid Hospitalization After Release with a Misdiagnosis—ED Stroke/Dizziness)
Supporting Rationale:	Considering that dizziness is a patient-reported symptom and older adults commonly report dizziness when they may be experiencing lightheadedness or poor balance due to loss of muscle strength and balance,[3,4] we recommend ensuring the *Stroke SPADE* measure requires thorough history, documentation, and coding by the clinician.

***

Thank you for taking the time to review our feedback and recommendations. For additional information or if you have any questions, please do not hesitate to contact, Anna Kim at akim@americangeriatrics.org.

Sincerely,

Nancy E. Lundebjerg, MPA
Chief Executive Officer

[3] Jahn K, Kressig RW, Bridenbaugh SA, Brandt T, Schniepp R. Dizziness and unstable gait in old age: Etiology, diagnosis and treatment. *Dtsch Arztebl Int.* 2015;112(23):387-393. doi:10.3238/arztebl.2015.0387
[4] Nnodim JO, Yung RL. Balance and its clinical assessment in older adults – A review. *J Geriatr Med Gerontol.* 2015;1(1):1-8. doi:10.23937/2469-5858/1510003