ANNOUNCEMENT
Retirement of PQI 13, "Angina without Procedure Admission Rate"

This announcement is to inform users of AHRQ Quality Indicators (QIs) that Version 6.0 (2016) of the QI software will not include PQI 13, "Angina without Procedure Admission Rate." Version 5.0 of the QI software will be the last release in which this indicator is included.

Since the development of PQI 13 "Angina without procedure admission rate", new evidence and uses of the PQI have raised concerns regarding its validity. These concerns, outlined below, were reviewed and discussed by an AHRQ Quality Indicator workgroup in November 2013. At that time, the workgroup recommended that PQI 13 be retired.

The evidence that has led to this action includes the following:

PQI 13 rates have declined each year since the development of the PQIs, from 81.5 per 100,000 population to 15.7 per 100,000.[1] A review of angina related hospitalization from 1992-1999 using Medicare data found that declines were associated with shifts in coding practices, namely increase use of codes specific for coronary artery disease (the underlying disease) rather than angina (the manifestation of that disease). This shift in coding greatly reduces the validity of this measure, as originally intended, to reflect access to care.

A second concern about this indicator is the increased use of chest pain units (CPU) in emergency rooms and new regulations from CMS, the so-called "two midnight rule," (CMS-1599-F) which has increasingly shifted coding short stays as "outpatient" observation stays. Use of observation services may decrease the number of chest pain admissions; this shift may be clinically appropriate, but differences in the availability and use of these units between counties may result in differing rates, while the underlying burden of disease remains constant.

Finally, by excluding hospitalizations that involve procedures, PQI 13 could inadvertently incentivize the performance of more procedures, even though clinical trial evidence suggests that most patients with angina can be managed just as effectively with medications.[2] While it is unclear whether this incentive impacts county-level measures (the level for which the PQI was designed and validated), as the PQI is adopted for other denominators (e.g., by healthcare systems and insurers to track quality within their groups of providers) the risk for perverse incentives increases, and could not only affect care but also eventually impact the validity of the county level measurements as reflection of appropriate care.

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[1] Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, State Inpatient Databases, quality analysis file (2012) and AHRQ Quality Indicators, version 4.4. The quality analysis file is designed to provide 2012 national estimates using weighted records from a sample of hospitals from 44 States, using the same methodology employed for the 2000-2011 Nationwide Inpatient Sample.

[2] Amsterdam EA, Wenger NK, Brindis RG, Casey DE Jr, Ganiats TG, Holmes DR Jr, Jaffe AS, Jneid H, Kelly RF, Kontos MC, Levine GN, Liebson PR, Mukherjee D, Peterson ED, Sabatine MS, Smalling RW, Zieman SJ. 2014 AHA/ACC Guideline for the Management of Patients With Non-ST-Elevation Acute Coronary Syndromes: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. J Am Coll Cardiol. 2014;64(24):2645.