ACC/AHA Editorial

New Quality Measure Core Sets Provide Continuity for Measuring Quality Improvement
Concerns Raised About Conflicting Blood Pressure Measures

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For more than a year, the American College of Cardiology (ACC) and the American Heart Association (AHA) have participated in the Core Quality Measures Collaborative, an important national effort convened by the Centers for Medicare and Medicaid Services and America’s Health Insurance Plans. The Collaborative is made up of representatives from private health plans, the National Quality Forum (NQF), physician specialty societies, employers, consumers, and other groups with an interest in improving the quality of health care. The goal of this Collaborative is to achieve broad consensus on core measure sets that are aligned across public and private payers and will reduce the burden of reporting, while contributing to improved quality of care and providing meaningful information for consumers.

After much work, the Collaborative has released its first 6 core quality measure sets, addressing a number of areas of clinical practice including cardiology.1 The release of these initial core measure sets is a significant achievement, and we commend the Collaborative for its success in uniting numerous stakeholders behind a common cause. The hard work of Collaborative members to reach consensus is a testament to their commitment to improving the reporting of health care quality information for the benefit of patients.

However, consensus is not unanimity, and there is 1 major decision with which the AHA and ACC strongly disagree because of its potential to harm millions of patients. Among these initial core measure sets are 2 that include measures addressing blood pressure (BP) control for patients with hypertension. In each of these sets, 2 BP control measures are offered as either/or choices. One of these measures (NQF #0018) defines adequate control as <140/90 mm Hg; the second measure (Healthcare Effectiveness Data and Information Set [HEDIS] 2016) relaxes the target for adequate control to <150/90 mm Hg for patients age 60 years and older without diabetes mellitus or chronic kidney disease.

Although we recognize that the inclusion of these 2 measures was a compromise agreed to by the members of the Collaborative to achieve a consensus, the AHA and ACC have concerns with the inclusion of the HEDIS 2016 measure in these core measure sets because of its likelihood to increase the number of inadequately treated patients with high BP, who would then be at greater risk for heart disease and stroke. It would be inconsistent with the missions of both the ACC and AHA, which are focused on transforming cardiovascular care and helping build healthier lives free of cardiovascular diseases and stroke, if we did not alert patients and the medical community to this risk.

The recommendations upon which the HEDIS 2016 measure is based were made in a 2014 paper published in The Journal of the American Medical Association,2 which is often incorrectly referred to as the “JNC 8 guideline.” This paper was written by members of the group originally empaneled to write the Eighth Joint National Committee (JNC) guideline, but this effort was discontinued by the National Heart, Lung, and Blood Institute (NHLBI). The paper was not sanctioned by the NHLBI, nor was it endorsed by the AHA, ACC, or any of the 44 other public, private, voluntary, and federal organizations that endorsed JNC 7 and earlier guideline versions. Officially, there is no JNC 8 guideline—a fact acknowledged by the authors and by The Journal of the American Medical Association in their wording of the paper’s title.

In addition, a subset of the original panel wrote and published a clearly argued disagreement with the BP target section of the document, saying the full span of available evidence was not addressed, including the issue of stroke as an endpoint for trials in the treatment of high BP.3 Modelling studies strongly suggest that raising the target BP to 150/90 mm Hg is highly likely to lead to an increased number of preventable strokes, placing a substantial burden of disability for patients and their families. This potential increase in preventable strokes across the population is the chief concern of the ACC and the AHA. Even with the current target of 140/90 mm Hg, many patients treated for high BP are not adequately treated to goal; raising the BP target will suggest to these patients and their health care providers that their previously inadequate treatment has suddenly become adequate.

The release of the NHLBI-funded SPRINT (Systolic Blood Pressure Intervention Trial) trial data late last year only validates our concerns that raising the target BP for these patients...
will have an adverse effect on the public’s health and potentially undermine decades of progress in improving the outcomes of treatment for cardiovascular disease. The SPRINT trial was stopped more than a year early due to “potentially lifesaving information” when early results of the study suggested that aiming at an even lower target BP (120 mm Hg systolic) was beneficial in reducing the trial’s composite endpoint when treating high BP. Finally, the decision by an NQF expert standing committee not to recommend endorsement of the HEDIS 2016 measure when it was submitted for ad hoc review last year is a very real and serious indication of the continuing uncertainty about the wisdom of recommending a higher threshold for BP control. In making their decision, NQF was, in effect, refusing to base a change in target on a document that is not one in the series of highly commendable and widely endorsed JNC reports.

The AHA and ACC are currently in the process of developing a guideline for high BP treatment that will evaluate the full span of the evidence, including the endpoint of stroke. We anticipate the revised guideline will be released later this year. The AHA and ACC are encouraged by the commitment expressed by the Core Quality Measures Collaborative to review the recommendations of the new guideline when they are available and to adopt changes in the core measures as appropriate. Until the new guideline is published, we urge, as we did in an advisory along with the Centers for Disease Control and Prevention in 2014, all health care providers and patients to strive to reach a BP target of <140/90 mm Hg. To do otherwise puts patients’ lives and well-being at risk. We also urge all patients to talk to their doctors about their own risk for cardiovascular disease and stroke and to learn what steps they can take to reduce it.

**References**


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