1. **How are you using health IT enabled clinical quality measures for internal quality improvement efforts and patients care?**

Sharp Rees-Stealy medical group (SRSMG), a 400-physician multispecialty group located in San Diego currently participates in California's Pay for Performance (P4P) program, coordinated and governed by the Integrated Healthcare Association (IHA). IHA is responsible for collecting data, deploying a common measure set, and reporting results for approximately 35,000 physicians in about 200 physician groups. The program is aided by a technical team including experts from the Pacific Business Group on Health (PBGH), the National Committee for Quality Assurance (NCQA) and IHA staff.

The P4P program includes four domains - clinical quality, patient experience, information technology, and appropriate resource use. The approved measurement year (MY) 2011 measurement set is included with this written testimony. The clinical quality measures are mostly HEDIS-derived, with modifications to enable use at the medical group or IPA level. Two key points about the IHA P4P program - it relies exclusively on administrative data, and the health plans' patients are aggregated so that physician organizations receive only one score per measure for the program. The MY2011 clinical measures include:

1. Childhood Immunization Status –Combination of all Antigens
2. Appropriate Testing for Children with Pharyngitis
3. Appropriate Treatment for Children with Upper Respiratory Infection
4. Chlamydia Screening in Women
5. Evidence-Based Cervical Cancer Screening
6. Breast Cancer Screening – Ages 40-69
7. Colorectal Cancer Screening
8. Cholesterol Management LDL Screening (Pts. w/ Cardiovascular Conditions)
9. Cholesterol Management: LDL Control <100 (Pts. w/ Cardiovascular Conditions)
10. Medication Monitoring (ACE/ARBs, Digoxin, and Diuretics)
11. Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis
12. Use of Imaging Studies for Low Back Pain
13. Adolescent Immunizations – Combination of Tdap and Meningococcal
14. Asthma Medication Ratio
15. Diabetes Care: HbA1c Screening
16. Diabetes Care: HbA1c Poor Control >9%
17. Diabetes Care: HbA1c Control <8%
18. Diabetes Care: HbA1c Control <7%
19. Diabetes Care: LDL Screening
20. Diabetes Care: LDL Control <100
21. Diabetes Care: Nephropathy Monitoring
22. Diabetes Care: Blood Pressure Control for People with Diabetes <140/90
23. Optimal Diabetes Care Combo 1 (LDL<100, HbA1c<8%, Nephropathy Monitoring)

Clinical quality measures are reported in two ways: 1. Audited health plan data are submitted to NCQA for aggregation and scoring; 2. Physician organizations self-reported clinical quality scores are accepted

after passing NCQA-certified audit. The final score used for payment and public reporting is the higher of the two methodologies.

Sharp Rees-Stealy is a self-reporter and maintains a robust data warehouse that includes encounter data, demographics, laboratory, pharmacy, claims, hospital, ED, EHR, and enrollment data. The data warehouse produces P4P and all other quality reports that are used for clinical quality improvement. For example, SRSMG has developed diabetes, cardiovascular, and preventive care registries that produce reports at patient, physician, site and group level for quality reporting and process improvement efforts. The results of these registries are visible within a window in the EHR (Allscripts Enterprise) so the practicing physician can view gaps in care.

The current health IT enabled clinical quality measures are not (yet) included in the P4P measurement set, and therefore not used by SRSMG for internal or external quality reporting or patient care purposes. The health IT enabled clinical quality measures offer great promise for expanding the P4P clinical measurement set. If the health IT enabled clinical quality measures were to become part of the accepted IHA measurement set in the future, then that harmonization would lead to a synergy of quality efforts, magnifying the potential for population health improvements.

I currently serve as the Chair of the IHA Technical Quality Committee (TQC) whose responsibilities include the selection, vetting and monitoring of the measurement set, subject to the approval of the IHA P4P Steering Committee. The TQC includes representatives from California physician organizations, health plans, employers, consumers, and technical experts from IHA and NCQA. The TQC is very interested in the development of the health IT enabled clinical quality measures in order to create a more robust measurement set, harmonize quality initiatives, minimize duplicative reporting requirements, further engage specialists, and reduce overall cost of care.

In order for health IT enabled clinical quality measures to be recommended by the TQC and adopted by the IHA P4P program, these measures must pass the usual committee processes. These processes include

- An evaluation of the measure for importance (health and financial impact), scientific acceptability, feasibility, and usefulness
- An estimate of prevalence and numerators and denominators to assure that a majority of physician organizations can be scored
- Specification of the data elements and the inclusion and exclusion criteria
- Vote by the TQC and P4P steering committee to proceed with testing
- 1 year of testing of performance using actual P4P data
- Public comment period for stakeholder feedback
- Final vote and inclusion into the measurement set

I anticipate that the health IT enabled clinical quality measures would be required to follow the same pathway for ultimate adoption into the P4P measurement set. It is my expectation that the health IT

enabled clinical quality measures will be determined to be important and scientifically acceptable. However, the challenge with many measures is whether they are sufficiently specified and tested to ensure they are feasible to measure and results are useful. It remains to be seen whether the health IT enabled clinical quality measures of meaningful use will meet these criteria.

2. **How have the electronic clinical quality measures brought value for external reporting requirements? Has there been added efficiency for the organization as a result?**

As indicated above, the current electronic clinical quality measures have not yet brought value to SRSMG for external reporting. The hope is for harmonization of these two quality initiatives (clinical quality measures of meaningful use and P4P).

How are you using health IT enabled clinical quality measures in other local or regional quality improvement efforts?

SRSMG is participating in California's Right Care Initiative, a statewide effort to improve quality outcomes in diabetes and hypertension. San Diego has formed a regional steering committee to guide the project, and efforts are underway to facilitate quality reporting among San Diego's medical groups and IPAs. The use of standards for benchmarking and improvement documentation will be critical, and the health IT enabled clinical quality measures may prove useful as the measurement specifications.

In addition, SRSMG participates in national collaboratives through the American Medical Group Association, and similarly, the health IT enabled clinical quality measures may be able to serve as the standard for benchmarking and improvement.

3. **Explain the challenges and strengths of current e-specified clinical quality measures and the ability of your current EHR product to capture and report the measures**
    a. **What have been the greatest challenges in generating (implementation, calculation, and reporting) electronic quality measures?**

In order to report these measures, SRSMG required an upgrade to Allscripts Enterprise version 11.2 which has so far been unsuccessful. The upgrade issues involve both hardware and software. The implementation thus has been delayed.

In addition, each measure requires careful examination of workflow in order to minimize disruption to office practice. Each measure may require extensive physician, clinical staff, and EHR changes. For example, the tobacco use assessment and tobacco cessation intervention measure required changes in rooming policy, training of clinical staff, creation of monitoring reports for compliance, changing policy to allow access to the active problem list by clinical staff, coding training of physicians, and standardization of the documentation of cessation interventions.

    b. **What are the challenges of data mapping of clinical processes to data elements in the EHR (i.e. to achieve numerator and denominator counts)**

The main challenge is the training of physicians in the correct coding and proper documentation of the patient's problems, including applicable exclusions. For example, SRSMG has had extensive physician education to the American Diabetes Association criteria for diagnosing diabetes, and the importance of coding and documenting polycystic ovarian disease, gestational pregnancy, and steroid-induced diabetes – exclusions for the diabetes measures. This is an ongoing requirement in order to maintain the integrity of the EHR problem list and properly assign patients to the correct measure. Another tricky example is the documentation of sexual activity in the female 15-24 age group for the Chlamydia screening measure.

c. Is the "menu" option for reporting clinical quality measures by specialty an appropriate structure for engaging provider participation in meaningful use?

Yes, although most of the measures are still primary care based. I hope that more specialty measures can be added to the menu set.

4. In planning stage 2, would you continue or modify stage 1 quality measures to be more valuable to your practice?

I would recommend modification of the measures, whenever possible; to fully align with HEDIS and other performance measurement programs, including ACOs, Medicare Stars, state P4P programs, and private insurance quality contracts.

Control of hypertension is an example of an important clinical measure that calls out for alignment of the health IT enabled clinical quality measure and the HEDIS measure. The current HEDIS hypertension control measure requires the hybrid methodology with manual chart review to confirm the diagnosis of hypertension. Since the health plans are held to the HEDIS standard, this translates to reluctance to adopt a non-HEDIS hypertension performance measure for payment or public reporting in California's P4P program. Thus, the movement to a fully electronic measure is slowed by health plans' desires to align P4P with their quality objectives (i.e., HEDIS) and the lack of health plan resources to program two measures for one condition. The solution is for full NCQA testing and endorsement of the electronic version of these measures.

5. What is your reaction to proposed measure concepts and the proposed additional e-specified clinical measures for stage 2? Would they add value to your clinical measurement and quality improvement activity? Would they be helpful to your participation in external recognition, reporting, and payment programs?

The measures concepts are appropriate to medical group management of a patient population over time. Some of these measures concepts appear more appropriate to measure on a systems (medical group or hospital or ACO) level rather than at an individual physician level, such as health equity, hospital associated events, or ambulatory care sensitive preventable admissions. In contrast, some of

the measures concepts appear to be better measured through patient surveys of experience of care rather than through an EHR. It is unclear to me if these measures will add value to the clinical management and quality improvement activities of SRSMG, although many are strategies and tactics we are pursuing or considering in improving population outcomes.

The key thing to focus on is maximizing alignment of performance measures across programs; not just the measure concept, but moreso alignment of the detailed specifications.

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