Overview of Presentation
- PCPI and PCPI Measures related to Gastroenterology
- Specifications for Different Data Sources
- Lessons Learned in EHR Implementation Projects
- Example of Measure for Gastroenterology

PCPI Mission

Improve patient health and safety by:

- Identifying and developing evidence-based clinical performance measures and measurement resources that enhance quality of patient care and foster accountability
- Promoting the implementation of effective and relevant clinical performance improvement activities
- Advancing the science of clinical performance measurement and improvement

Current PCPI Membership

- More than 100 national medical specialty and state medical society representatives
- Council of Medical Specialty Societies
- ABMS and member boards
- Experts in methodology and data collection
- 13 Health care professional organizations (NEW)
- Agency for Healthcare Research and Quality
- Centers for Medicare and Medicaid Services
- Individuals/organizations committed to health care quality improvement and/or patient safety, and participants in the development, review, dissemination or implementation of performance measures and measurement resources
- Convened and staffed by AMA

PCPI Portfolio

- Over 250 measures in 43 Clinical Conditions
- More than 100 measures are NQF-endorsed™ and/or AQA selected
- 112 of the 153 total measures in the CMS Physician Quality Reporting Initiative (PQRI) for 2009 were developed by the PCPI in collaboration with the National Committee for Quality Assurance (NCQA) and/or with a medical specialty society

*updates can be accessed at www.physicianconsortium.org

PCPI Portfolio

- PCPI measures used in several CMS demos: MCMP, Physician Group Practice, EHR Demonstration Project
- Used in ABIM practice improvement modules; American Academy of Family Medicine CME program
- Technical specifications available to integrate measures into any EHR product
- Testing within EHRs
Use of measures in CMS demonstration projects

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<th>QI Initiative</th>
<th>PCPI measures used</th>
<th>Data Source</th>
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<td>Physician Quality Reporting Initiative</td>
<td>Of the proposed 153 measures designated by the CMS for the 2009 PQRI, 112 measures were developed by the PCPI with medical specialty societies, and often in conjunction with the NCQA.</td>
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<td>Physician Group Practice demonstration</td>
<td>Coronary artery disease, Diabetes, Heart failure, Preventive care and screening</td>
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<td>Medicare Care Management Performance Demo</td>
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PCPI Measures Available for Use by Gastroenterologists

- Endoscopy and Polyp Surveillance (3)
  - Co-Developers NCQA, AGA, ASGE

- GERD (5)
  - Co-Developers NCQA, AGA

- Hepatitis C (10)
  - Co-Developer AGA

- Exposure Time Reported for Procedures using Fluoroscopy (Radiology Set) (1)
  - Co-Developer NCQA, ACR

- Pediatric Acute Gastroenteritis (4)
  - Co-Developer AAFP

Specifications for Different Data Sources

- Electronic Health Record (EHRs)
- Other HIT
- Claims/Administrative Data
- Paper

Specifications for Different Data Sources - Claims

- Claims/Administrative Data
  - ICD-9, CPT, HCPCS, CPT® Category II Codes
  - Used in CMS PQRI Program
  - Reported on claims
  - Denominator identified by Administrative Codes
  - Numerator reported using CPT II
  - Exceptions reported via modifiers
  - Can provide feedback on reporting rate, performance rate, exception rates by categories

Example-Claims/Administrative Data

- Denominator
  - Patient ≥ 18 years of age
  - Receiving surveillance colonoscopy with a history of prior colonic polyp in previous colonoscopy
  - ICD-9 CM: V12.72 (Hx of Colonic Polyps)
  - CPT or G-Codes: 44388, 44389, 44392, 44393, 44394, 45355, 45378, 45380, 45381, 45383, 45384, 45385, G0105 (Procedure codes for Surveillance Colonoscopy)

Example-Claims/Administrative Data

- Numerator
  - Patients who had an interval of 3 or more years since their last colonoscopy
  - CPT Category II Code
    - 0529F-Interval of at least 3 or more years since patient’s last colonoscopy, documented
Example-Claims/Administrative Data

- Exceptions
  - Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)
  - Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report incomplete)

- CPT Category II Codes
  - 0529F-1P (medical reason)
  - 0529F-3P (system reason)

Specifications for different data sources - EHRs

- "Level I"
  - Understandable/useful to physicians, other health care providers, EHR vendors, developers of clinical decision support
  - Includes "logic," and codes and algorithms to calculate measures
  - Unambiguous
  - Puts specifications into a standardized, technical format

EHRs Level I Specifications

- Use Clinical Code Sets to specify measures
  - SNOMED-CT, LOINC, RxNorm
  - Added specificity around data elements (date, order or result, current medication on medication list)
- Utilize existing maps
  - SNOMED-CT
  - CPT
  - ICD-9
  - LOINC

Example- EHRs (Level I Specs)

- Denominator
  - Patient ≥ 18 years of age
  - Receiving surveillance colonoscopy with a history of prior colonic polyp in previous colonoscopy
  - SNOMED CT
    - History of Colonic Polyps: 429047008, 428283002
    - AND
    - Colonoscopy: 73761001, 235150006
    - AND
    - Has intent (attribute) 363703001
    - AND
    - Surveillance: 225419007

- Numerator-Patients who had an interval of 3 or more years since their last colonoscopy
  - SNOMED-CT
    - Colonoscopy previously performed (at any time in past): 73761001, 235150006
    - AND
    - Has intent (attribute) 363703001
    - AND
    - Surveillance: 225419007 OR Screening: 360156006
    - AND
    - Date of procedure is at least 3 years prior to date of current procedure

Example-EHRs (Level I Specs)

- Exceptions in EHRs
  - CPT Category II option for reporting exceptions
  - Exploring process to request SNOMED-CT codes to represent exceptions
EHR Level II Specifications

- AMA/NCQA/EHRA Collaborative
- Developed prototype standardized format and reference guide for representing specifications for IT specialists—using XML schema (HQMF)
- That initial work and work of others now being reviewed and shepherded by NQF (via contractor) through SDO (eMeasure)

Lessons Learned: the Cardio-HIT project

- 6 physician practices (small and large, cardiology and internal medicine, different EHR system)
- All experienced users of EHR but not for quality measurement and reporting
- Funded by Physicians Foundation for Health System Excellence (phase 1) and AHRQ (phase 2)

Lessons Learned: the Cardio-HIT project

- SNOMED codes not widely used in EHRs today
- NDC codes and timing
- Availability of practice reports prior to data export
- High agreement for exceptions reported to warehouse and found upon manual EHR abstraction
- Also high agreement with a priori list of exceptions

Next Steps

- Work with AMA/NCQA/EHRA Collaborative to determine
  - Appropriate format for Level I specs
  - Recommendations for drug coding (NDC, RxNorm, NDF-RT)
- Coordinate with NQF on standardized format for specification submission
- Proactively identify within PCPI measures appropriate for EHRs

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