



## Quality Measures & Clinical Quality Workgroups

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Testimony Respectfully Submitted by:

Susan Chauvie, Vice President, Quality *and* Practice Transformation

OCHIN, Inc. and Oregon's-Health Information Technology Extension Center (O-HITEC)  
707 Southwest Washington Street, Suite 1200 |Portland Oregon |97205 |503.943.2500

Susan Chauvie serves as **Vice President**, Quality and Practice Transformation, for OCHIN Inc., a Health Center Controlled Network (HCCN) and O-HITEC, the designated Regional Extension Center for the state of Oregon. She provides the network-level vision, strategy and leadership to achieve meaningful and transformational practice improvements across a diverse group of collaborative organizations in seven states. Previously, Ms. Chauvie was OCHIN's Chief Clinical Officer (2004-2010). Championing the importance of clinical quality improvement and practice-based research as a springboard to meaningful practice change, Ms. Chauvie is a founding member of OCHIN's Community-Based Practice-Based Research Network and the principle liaison between OCHIN's clinical leaders and scientific researchers for clinical research collaborations and is currently a co-investigator of nine AHRQ, HRSA, NIH and NMIH grants. Ms. Chauvie has extensive clinical, operational and administrative experience in public and private health care settings with a primary focus on clinical quality improvement, professional coaching, clinician facilitation and program development. Ms. Chauvie graduated from Portland State University (MPA/HA) and the University of Portland (BSN).



## Background:

### An Organizational Description

OCHIN is a Health Center Controlled Network (HCCN) providing a hosted implementation of an ONC-ATCB certified integrated practice management (PM) and electronic health record (EHR) system serving 50 separate organizations and over 400 individual clinics comprised of federally qualified health centers (FQHCs), FQHC “look-alikes”, rural health centers (RHCs) and small practices across 7 states. OCHIN was formed in 2000 with the intent to provide a world class, fully integrated EHR built on a single master patient index, data and information, consultation and a myriad of support services to best support health care delivery community clinics. Today OCHIN maintains the HCCN as well as being:

- The HIT Regional Extension Center for Oregon
  - Host platform, manage and support three EHR vendor products (*Epic, eCW & Allscripts*)
  - Support two additional EHR vendor products (*hosted by local IPAs- Greenway & NextGen*)
- A practice based research network (PBRN) engaged in original and comparative research on safety net populations and serving as one of four HRSA funded national research nodes conducting comparative effectiveness observational and intervention studies and establishing improved approaches for transferring research results to community health treatment settings.
- An advanced health information exchange including with more than 250 interfaces and an operational near real time exchange of information with EHRs at external organizations.
- A centralized business services division providing all aspects of a clinic’s back office billing needs.
- A consulting division offering expert advice on implementation and optimization of EHR systems as well as grant writing, human resources and compliance best practices, contract negotiations, and system selection and planning.
- A data aggregation business service offering an array of benchmarking tool sets designed normalize clinical and operational quality metrics and benchmarks for ambulatory implementations and critical access hospitals. This tool set provides the foundation for quality improvement activities across multiple vendor platforms.
- A center for the education of health care and IT professionals on practical methods, techniques, and applications for performance improvement.

In 2011 OCHIN will support more than 2.5 million outpatient visits and grow beyond 50 organizations. OCHIN has 130 FTEs and an annual budget of \$20M. As a not for profit 501C3, OCHIN partners with communities to create the knowledge and information solutions to promote access, high quality, and affordable healthcare for all. We remain steadfastly committed to our vision of transforming the delivery of health care.



## Outline of Oral Testimony

### **What is your experience with electronic quality measures required under Stage 1 of Meaningful Use and the characteristics that made them (1) easier or harder to implement and (2) more or less supportive of accurate quality reporting.**

With more than six years of experience in implementing, optimizing and supporting a single hosted EHR in more than 200 ambulatory care settings, with the explicit objective to make a difference in the health outcomes of patients served, prior to the announcement of Stage 1 we were actively working on the quality measures required and currently most member clinics have successfully met the requirements.

The characteristics that made them easier to implement were we had already been working on them and once they were identified as Meaningful Use Measures we found them to be clear and a rational place to start.

Another very important reality that made meeting the Stage 1 Meaningful Use quality measures possible for the OCHIN clinics to achieve was the combined resources and support HCCN and HIT Regional Extension Center under one roof. Community health centers and small private practices are generally doing all they can to meet the demand of patients needing to be seen. Few if any can afford to create the reporting foundation and infrastructure to measure and improve clinical quality measures without additional support of both a HCCN and Regional Extension Center.

The challenge of having these measures accurately serve as quality reporting is the translational bridge that is needed between clinical application and relevance and technical interpretation of each measure and how to retrieve the data. Only when there is a true understanding of what a measure means and why, along with variations in clinic workflows and how the EHR used by clinicians can technical experts competently extract the needed data elements for reporting. Without this level of understanding and translation, technical experts with the best of intentions will generate performance reports that aren't reflective of actual performance, thereby prompting all kinds of problem solving that generally boils down to forced workflow changes of many clinicians.

A secondary challenge is that if these measures are to accurately reflect actual care quality and contribute in a meaningful way to health care reform and payment restructuring, then there must be some provision to require inclusion of socioeconomic demographic information and risk stratification for 'known social determinates' of care. Health care and payment reform must somehow address these topics if we are to have a viable solution for the long-term.

### **Reflect on the characteristics needed to make Stage 2 and 3 quality measures optimally implementable and that add value for quality improvement, public reporting, payment, and similar programs.**

The characteristics needed to make Stage 2 and 3 quality measures optimally implementable and that add the highest value for quality improvement, public reporting, payment reform and similar programs are:

- ✓ Derive measures from highest level of evidence that it does more good than harm and is cost effective
- ✓ Strike a balance between keeping the threshold increases meaningful and achievable (given the variables pertinent to the measure) with the need to push on expectations of the highest risk and most expensive conditions
- ✓ Include clinical quality measure(s) that captures the benefit of integration between primary care and behavioral health in the medical/health home model of care
- ✓ Include socioeconomic, race and ethnicity demographics for risk stratification to better understand populations served and what it takes to care for them
- ✓ Include clinical quality measure(s) that requires collaboration with public health agencies
- ✓ Include clinical quality measure(s) that require electronic lab orders; require all labs to accept electronic orders and to electronically send results back to file in the patient HER



- ✓ Include clinical quality measure(s) that require consolidation of emergency room, hospital, and other care delivery location data.

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## Panel 1: Care Provider Panel Themes and Questions

- **How are you using health IT enabled clinical quality measures for internal quality improvement efforts and patient care?**

Decision Support Tools (DST) have been created and are being used to prompt care providers and care team members of best practice preventative and disease/condition-specific activities. We have focused most of our attention on the DSTs that provide support for the high volume, high volume/high risk and low volume/high risk categories of care. (*Preventative, Diabetes, Depression, Obesity, Drug and Alcohol screening, HIV, Family planning, behavioral health integration, etc.*) All of our DSTs are linked to a web-based reporting tool for instant clinical quality performance measurement down to the individual patient and provider level and rolled up to the network wide level for comparison. Gaps in care are easily spotted and most of our clinics are embroiled in QI efforts to improve performance.

Care Registries for high prevalence disease conditions, care management, and population health (*Preventative care, Diabetes, Depression, Hypertension, Obesity, Chronic Pain, Well Child, OB, etc.*) have been designed to measure care delivered (*provider, clinic, organization, network level performance*) and to assist clinics in proactive care planning and intervention strategies for patients scheduled to be seen and those patients who are not scheduled to be seen and require active outreach. Care registries are actively used to measure quality of clinical and operational performance and to craft quality improvement interventions to address identified gaps in care delivery. These registries are shared across all of the OCHIN clinics and have served as a great equalizer among disparate clinic organizations and a springboard for sharing of lessons learned and best practices across the entire network.

Primary Care Medical Home has prompted a series of EHR and reporting changes to become maximally useful to the increasing numbers of clinics moving to this model of care delivery. All significant changes we have made have been accompanied by specific clinical quality measures that have generated quality improvement activities primarily around clinic staff practicing to their highest scope of licensure and capacity.

In summary, HIT enabled clinical quality measures are used to measure, evaluate and improve patient care at the individual provider/care team, clinic, organization and network levels:

- ✓ Measure provider & team performance - traditional registry and clinical dashboard
- ✓ Assess improvement efforts, policy change impact, clinic and/or network initiatives
- ✓ Assess population health, disparities, trends, regional differences
- ✓ Target patients for inreach/outreach
- ✓ Generate leadership level operations reports

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

The clinical quality measures have brought value for external reporting requirements in a variety of ways:

- ✓ It is significantly easier to electronically report to external agencies than anything on paper.
- ✓ These measures have been exciting to the clinicians who in the past viewed most clinic reporting efforts more of an administrative function rather than an opportunity to engage clinicians and care teams in improvement activities. The electronic clinical quality measures have become an equalizer among disparate clinics as the clinician leaders have rallied around them together.



- ✓ These measurements have also been useful in working with various states around public health surveillance data, with payers, Primary Care Associations, and in describing patients and care delivery in the OCHIN clinics to clinical researchers who want to study improvement methods, delivery models and comparative intervention strategies.
- ✓ There has been an increase in efficiency in our clinics and at the OCHIN Network level. Working together on the clinical quality measures has effectively accelerated a great deal of clinical quality tools, transformative community collaborations, and reporting development in a way that has been exciting to the clinicians. Excitement and enthusiasm has been further amplified with the alignment between Meaningful Use Stage 1, NCQA and Accountable Care Organization requirements. Understanding the alignment between these requirements gives confidence that performance measurement and improvement efforts will be synergistic and actually transform US healthcare.

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

Our clinical quality measures are recognizing actual clinical data (as a measurement) quality rather than the claims data, traditionally used prior to the advent of EHRs. Our clinical quality data are being used in multiple local, regional and national quality improvement and clinical research venues. A few examples are as follows:

- ✓ Several state payor incentivized Primary Care Medical Home initiatives with accompanying quality measures
- ✓ State-specific Primary Care Associations initiatives to aggregate clinical measures for dashboard reporting/ comparisons
- ✓ Local quality-based programs rewarding clinics for quality care that leads to preventable admissions (outcome measures)
- ✓ Robert Wood Johnson Foundation projects in many clinics recognizing and rewarding clinics for improving clinical quality measures, many of which are the same as ONC quality measures
- ✓ State-level collaborations on behavioral health and specialty mental health EHR integration strategies into primary care.
- ✓ Many clinics are part of Accountable Care Organizations
- ✓ OCHIN Practice-Based Research Network where clinical research opportunities are greatly enhanced by having agreed upon clinical quality measures, a shared EHR and standard clinic workflows to support this work. We currently have ten active research studies in process with at least 25% of our clinic organizations involved in research at any given time.

Two specific examples:

- ✓ Network wide HRSA grant (2 year) to improve three specific measures of care for patients diagnosed with Diabetes in five separate clinic organizations in two states and then spread of those quality improvement interventions across the OCHIN collaborative called Transforming Care Quality (TCQ)

The baseline and improvement percentages reflect an average across participating clinics:

	Clinical Measures	Baseline	Initial 5 Clinics Improvement (18mo)	10 Spread Clinics Improvement (18mo)
1	% patients with HbA1c done within past 6 months	66%	78.75%	77.33%
2	% patients with HbA1c <8 within past 12 months	65%	69.34%	67.33%
3	% adult patients screened for depression within past 12 months	5%	51.38%	55.45%



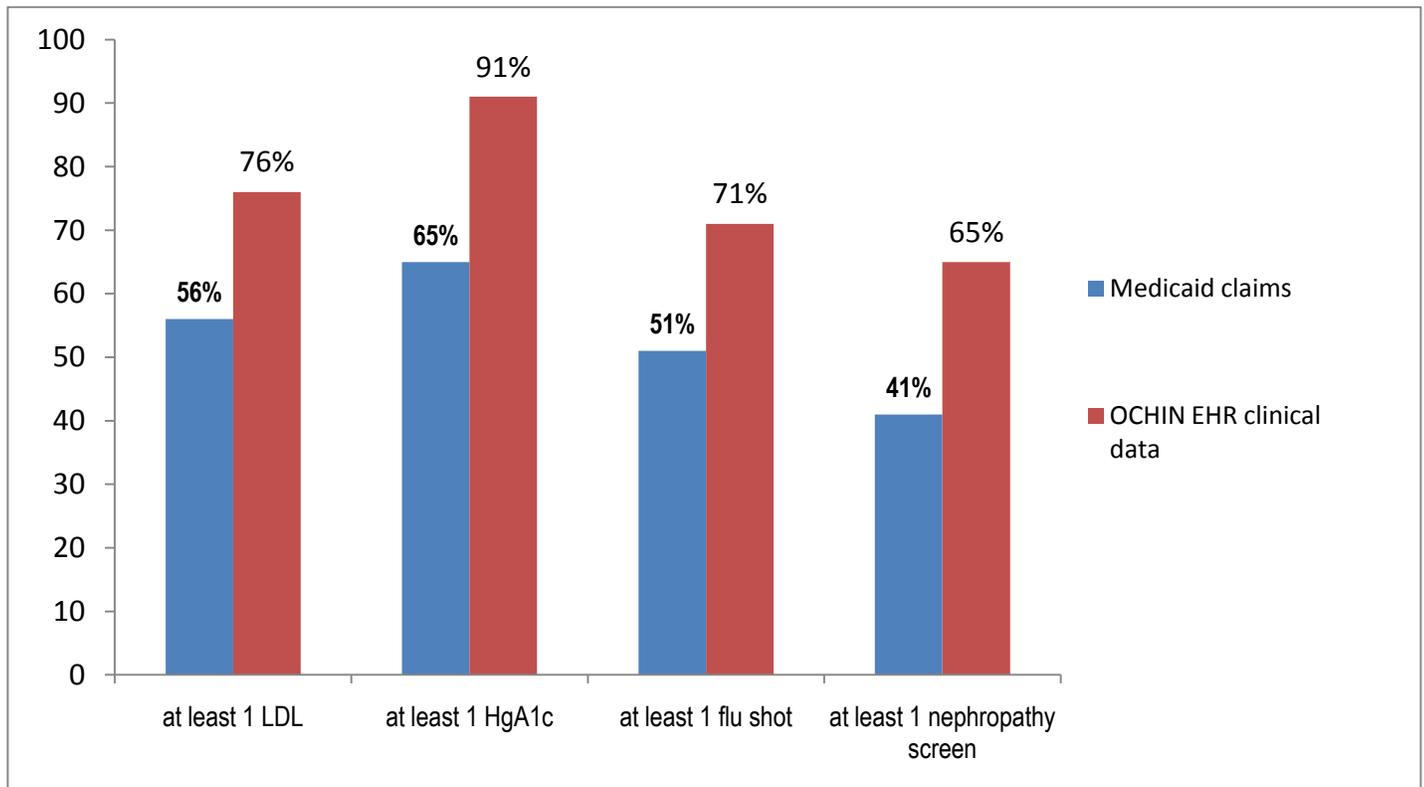
✓ Data validation study

**Hypothesis:** In a subset of established OCHIN diabetic patients (2005-2007), we tested the hypothesis that EHR data from OCHIN's linked network will contain more complete services utilization data than data found in Medicaid claims.

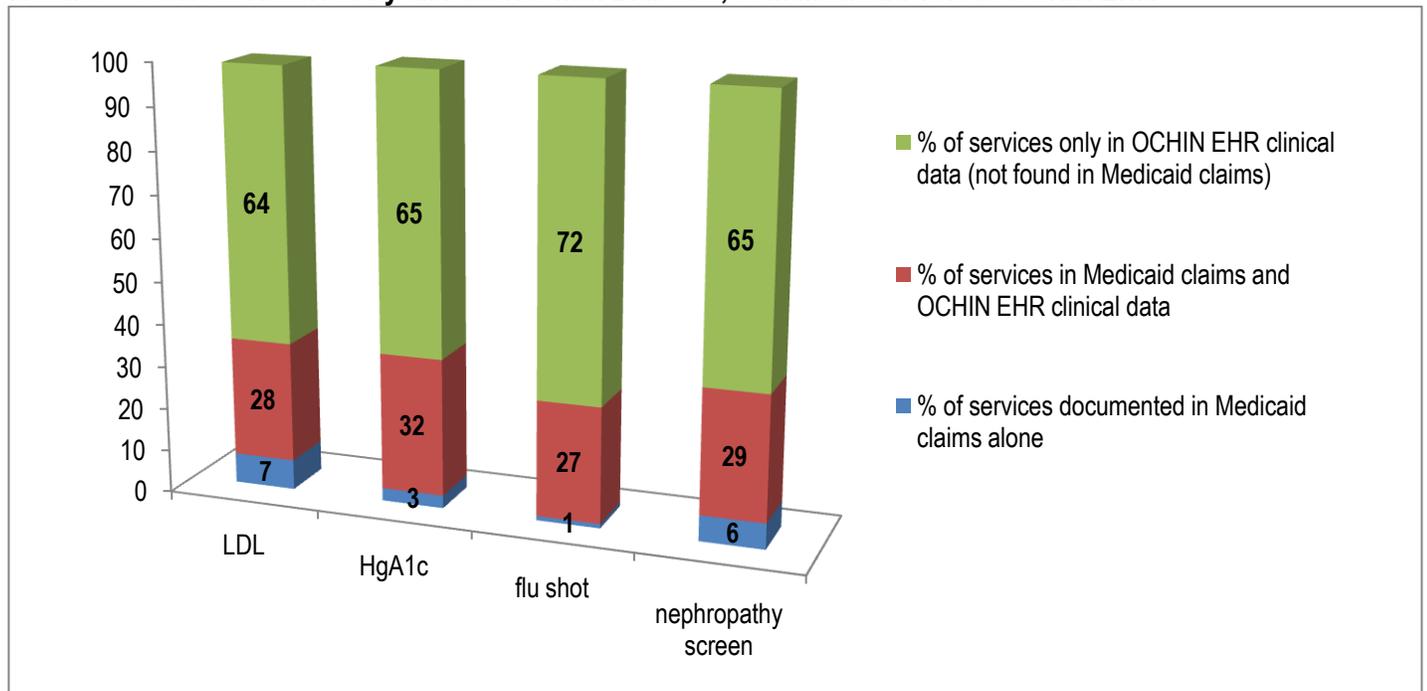
**Objective:** To establish linkages between OCHIN EHR and Medicaid claims and to examine congruence between these two data sources.

**Methods:** (1) Among those with a Medicaid identification number (n=2,103), we made linkages between OCHIN EHR and Medicaid data, then compared services documented in Medicaid claims data versus OCHIN EHR data. (2) Using the entire OCHIN diabetic population, we compared services documented in Medicaid claims data versus OCHIN EHR data.

**Results – Receipt of Diabetes Preventive Services Among 2,103 patients with Medicaid ID #**



## Results – Services Received by all Patients with Diabetes; % in Medicaid Versus OCHIN EHR



- 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
  - What have been the greatest challenges in generating (implementation, calculation, and reporting) electronic quality measures?
    - ✓ Interpreting and agreeing on shared data definitions to the level required to generate comparable reports and having well documented specifications. This includes what discreet fields in the EHR to pull data from. This has been further complicated by the fact that select local payor organizations have created their own clinical quality measures attached to Primary Care Medical Home clinic changes to reward successful participating clinics with their own versions of inclusion criteria, numerators and denominators that differ from the CMS definitions.
    - ✓ Many measures require a set of “business rules” for cleaning data coming from the EHR to account for a few correct or approved workflows that will assure data will be captured. For example, in our EHR the PCP is stored in at least five separate locations and either the organization makes a decision on which locations will capture data and map those all five must be mapped. This becomes an exponential challenge with the thousands of discreet data fields within an EHR and even further complicated when an EHR is shared across many organizations that must all agree and adhere to those decisions.
    - ✓ Level of staffing and expertise required to support the complexity of Drug Formularies. The “smarter” the EHR product the easier it is to manage. Some vendors have built their EHR system to allow e-Prescription Network (i.e. SureScripts) to manage all drug formularies centrally, others not.
    - ✓ The historical practice of using claims data as a marker and measurement of actual care delivered is now interfering with using actual clinical data. Claims data was the only data available before the advent of EHRs and for those patients who had a claim submitted for reimbursement a reasonable marker of care. But for self-pay patients, for whom there is no claim submitted, their care was never captured, making performance measurement in clinics with uninsured and underinsured patients a grossly incomplete picture of quality.



The transition from using claims based data as a marker of clinical quality to actual clinical data has not been easy and created a significant distraction to the needed alignment of clinical quality measures. Here is one example:

A Chartered Value Exchange (CVE)\* organization in one of the states we have clinic organizations continues to publish clinical quality measures on a public website using only claims data. A large proportion of patients seen in OCHIN clinics have no claims data. Knowing this, the organization continues to reaffirm their commitment to continue to publish incomplete claims data until clinics can get the CVE to accept clinical quality measures from the EHR.

\* CVE - A designation from the U.S. Department of Health and Human Services tasked with providing a neutral forum for sharing information with the public and operates using the following principles: All health care is "local." National goals and common standards are important, but real improvement needs to take place in local settings....Transparency in measuring and reporting accurate and meaningful information on quality and cost is the key to helping providers improve and consumers become engaged ...Collaboratives involving key stakeholder groups... hold the promise to foster needed reforms.

- ✓ Developing the infrastructure, training and skills for employing quality improvement strategies to improve care delivery and health outcomes. Just because clinics have access to more and more data and information, doesn't mean they automatically know what to do with it. Quality improvement requires training, infrastructure and support to make it happen, sustain it and spread it.
- **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 best EHRs are the ones in which there is some flexibility in *how* clinicians and care teams can use the application to render care. Providing this flexibility makes it easier for clinicians and care teams to tailor their practice and workflows to their specific needs but adds complexity to how to map the data to capture care delivered that meets measure criteria. *How* clinicians practice doesn't necessarily speak to *what* care elements are being incorporated. Another words, there can be many ways to provide high quality care, the challenge is in having all parties understand that there need not be one way to render care. In a network such as ours where we have hundreds of clinics across seven states it becomes impossible to even consider suggesting one single way to provide care or policing one way to do anything. Identifying some number of discreet workflows and discreet fields that can be used by clinicians" and then mapping these to collect pertinent data begins to make it easier for the clinicians to do the right thing AND have it count in performance measures.
  - ✓ Interpretation of measure requirements can become a quagmire. Transdisciplinary collaboration on how to interpret measure requirements and how technological support to map data elements to pull
- **Is the "menu" option for reporting clinical quality measures by specialty an appropriate structure for engaging provider participation in meaningful use?**

Yes, the menu option is a simple and appropriate structure for engaging provider participation.

- **In planning for Stage 2, would you continue or modify the Stage 1 quality measures to be more valuable to your practice?**

There would be a lot of value in modifying Stage 1 quality measures for Stage 2 requirements to make them more congruent with the way providers practice medicine. For example: Vital signs, height, weight and BP may not be useful for every visit – a patient who has a sprained ankle doesn't need a weight taken. Minor revisions that better reflect common practice, particularly as it relates to patient visits for acute minor injuries would go a long way in making some of the measures even more meaningful.



It also makes sense to step up on what thresholds are required as long as the goal is clinically relevant.

Consider the many ways there are to accomplish the same level of care quality. Clinical quality measures are so important we should focus on making it easier to capture whether something was completed without having to force workflow changes just to capture data. We need to make systems smarter, make it easier to do the right thing and make sure the mapping is complete.

In addition to the above the following additions to Stage 2 would add even more value to our practice:

- ✓ Derive measures from highest level of evidence that it does more good than harm and is cost effective
- ✓ Strike a balance between keeping the threshold increases meaningful and achievable (given the variables pertinent to the measure) with the need to push on expectations of the highest risk and most expensive conditions
- ✓ Include clinical quality measure(s) that captures the benefit of integration between primary care and behavioral health in the medical/health home model of care
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- ✓ Include clinical quality measure(s) that require consolidation of emergency room, hospital, and other care delivery location data.

Thank you for the opportunity to provide testimony on this important topic. Please feel free to contact me directly with any follow-up questions you may have.