Specifications for IT Investment Domain
Pay for Performance, Year 2

The IT Investment domain covers the use of information technology (IT) for two sets of activities. There are two measures of performance in the IT Investment domain:

- Measure 1— Integration of clinical *electronic* data sets for *population-based* management
- Measure 2— Electronic tools to support clinical decision making at the *point of care*

Scoring for Year 2

The IT Investment domain counts as up to 20% of the P4P reward, scored as follows, for qualifying activities that are in place by December 31, 2004

0% - Group does not demonstrate any functionality
5% - Group demonstrates one qualifying activity in either Measure 1 or Measure 2
10% - Group demonstrates two qualifying activities in either Measure 1 or Measure 2
15% - Group demonstrates three qualifying activities, at least one of which must be in Measure 2
20% - Group demonstrates four qualifying activities, two of which must be in Measure 2

Key words in the measure specifications that determine a group's eligibility:

- *Electronic* data, which applies to the entire domain
- *Integrated multiple* data sets, *not including eligibility*
- *Actionable* reports, showing patients who need action from a clinician
- *Population* management, independent of patient contact
- Patient *contacts* (visits, calls, electronic communications)
- Laboratory *results*
- Clinical *findings*

How P4P Evaluates Groups' Activities

P4P scores groups' activities according to the scoring algorithm above. Groups self-report to NCQA, the P4P Data Aggregator, via an electronic Survey Tool. For activities in Measure 1, they also send supporting documentation to NCQA; for activities in Measure 2, they send an attestation. NCQA evaluates the responses according to the specifications on the following pages and validates them via an audit in some instances.

Pay for Performance IT Investment Domain Grid
Year 2 Version, Final Version 3/29/04
(Clarifications noted by underlined text 4/28/04)

IT Measure 1	Description	Eligible Qualifying Activities (Group must demonstrate capability and actual use by physicians as of 12/31/04)	Examples of Eligible Qualifying Activities
Measure 1—Integrate clinical *electronic* data sets for *population-based* management	**Population management independent of patient contacts.** Rewards group-level integration of relevant electronic data sets, including only*: • Visits/claims • Lab results or claims • Prescriptions • Inpatient stays or ER visits • Radiology findings or claims • Clinical findings: blood pressure, BMI, tobacco use, substance abuse or other findings relevant to clinical guidelines and the ability to report at the patient level to practice sites or individual physicians. *Note: Eligibility lists do not count as a relevant data set—the use of eligibility data is assumed.	1) Use of electronic disease registry or data warehouse or other electronic data capability to produce any of the following on all eligible patients, for all practice sites, updated at least twice annually: • actionable reports on patients at the physician or practice site level, or production of a query list for physicians or practice sites, which integrate at least 2 of the data sets at left • registries of patients at the physician or practice site level that integrate at least 2 of the data sets at left 2) Internally – and electronically – generated numerator and denominator results for any of the 4 specific HEDIS measures that include lab results or clinical findings in numerator. Those measures include **only** the following*: • Cholesterol Management—LDL control • Comprehensive Diabetes Care—HbA1c control • Comprehensive Diabetes Care—LDL control • Controlling High Blood pressure. [Therefore, any group self-reporting either of the first two control measures, which are also in the clinical measure set for Year 2, gets credit for an IT Investment activity also] *Note: HEDIS measures of the presence of screening or testing, such as HbA1c testing or cervical cancer screening, do not count.	**Credit for one activity (each)** • A list of patients diagnosed with CHF by practice site (visits) showing hospitalizations and ER visits in the past year (inpatient or ER records). • A list of each physician's diabetic patients (visits and /or pharmacy data) with HbA1c above 9.5 (lab results). • Electronic query list for a practice site of children who visited the ER for asthma and had no follow-up visit to PCP. (ER records plus visit data). • Any of the 4 specific HEDIS measures that include lab results or clinical findings in numerator. • A list of eligible patients (visit data to find patients with contraindications) missing BCS (radiology findings or claims) or CCS (laboratory findings or claims). • Electronic query list or report for a practice site of each physician's patients with diabetes (visits and/or pharmacy data), and their clinical lab results, most recent visit (visits) and most recent pharmacy fills (1 condition, 3 data sets). • Electronic query list or report for a practice site, of all patients' most recent lab results and office visits. • A list covering all a practice's patients with hypertension (visits) and their last three blood pressure readings (clinical findings).

IT Measure 2	Description	Eligible Qualifying Activities (Group must demonstrate capability and actual use by physicians as of 12/31/04)	Examples of Eligible Qualifying Activities
Measure 2—Tools to support clinical decision making at *point of care*	**Management of individual patients during contact.** Rewards actual use of electronic clinical information at the point of care in the physician's office, by either: • 50% or more of primary care physicians in the group • primary care physicians serving 50% or more of commercial HMO/POS members in the group.	Accessing lab results electronically measured by: # of PCPs who use e-lab results and/OR # of patients assigned to PCPs who use e-lab results	• Before seeing a diabetic patient, the PCP queries and pulls up electronically the patient's last 3 HbA1c results, ordered by any physician in the group
		Producing electronically-generated prescriptions measured by: # of PCPs who use e-prescribing and/OR # of patients assigned to PCPs who use e-prescribing	• The PCP chooses medications, strengths and frequencies from a menu and produces either a fax from the office to the pharmacy or an electronic message to the pharmacy with the prescription and an electronic signature. No handwriting of content is involved
		Automatically checking drug-drug interactions before prescribing measured by: # of PCPs who use e-drug checks and/OR # of patients assigned to PCPs who use e-drug checks	• PCP utilizes an electronic tool that alerts him/her that the medication he/she is about to prescribe interacts with other medications; PCP may check a medical record to determine if the patient is taking any of the other medications, or may also get the patient's medication data electronically
		Accessing clinical notes from other physicians (or hospital) electronically measured by: # of PCPs who can access electronic clinical notes and/OR # of patients assigned to PCPs who can access electronic clinical notes	• PCP pulls up ER summary to review before or during a patient visit • PCP receives consultation reports from specialists electronically, in the patient's record or e-mail
		Accessing clinical findings such as blood pressure, BMI, tobacco use or substance abuse measured by: # of PCPs who access electronic clinical findings and/OR # of patients assigned to PCPs who access electronic clinical findings	• PCP views a patient's last three blood pressure readings electronically
		Receiving preventive or chronic care reminders electronically during, or the same day of (before) a visit measured by: # of PCPs who use e-reminders and/OR # of patients assigned to PCPs who use e-reminders	• PCP utilizes a point-of-care tool that provides a reminder that a diabetic patient in the office had an LDL reading at the last visit that was above 100 • PCP utilizes a point-of-care tool that notifies him/her that a child being seen is due for specific immunizations • PCP receives any electronic reminder listed in Appendix: Leapfrog Recommended E-Reminders

		E-mailing messages, clinical data and/or referrals between PCPs and patients and/or specialists, and the group measured by: # of PCPs who use e-mail and/OR # of patients assigned to PCPs who use e-mail	• Patients can e-mail the PCPs with questions and receive replies • PCPs send electronic referrals to specialists and to the group for approval **and** communicates and receives clinical information electronically

Appendix: Leapfrog Recommended E-Reminders

- CAD:
  - Aspirin and beta blocker use
  - Lipid measurement/management
  - ACE inhibitor after MI if evidence of systolic dysfunction
- Diabetes:
  - HbA1C measurement/management
  - Lipid measurement/management
  - Aspirin and ACE inhibitor use
  - Eye examination
  - Foot exams
- Cerebrovascular Disease
  - Warfarin use in atrial fibrillation
- CHF:
  - ACE inhibitor use
  - Documentation of systolic function measurement
- Prevention:
  - Adult immunizations (Flu, pneumonia, and Td)
  - Pediatric immunizations *(non-Medicare measure)*
  - Breast cancer screening
  - Cervical cancer screening
  - Colorectal cancer screening
- Pregnancy care *(non-Medicare measure)*
  - e.g., screening for Rh blood type, Hepatitis B, syphilis
- Respiratory infections:
  - Inappropriate use of antibiotics in viral upper respiratory infections (i.e., colds)
  - Use of recommended antibiotics in outpatient management of pneumonia
- Follow-up Care
  - 28-day follow-up of patients after discharge from the hospital with a primary hospital diagnosis of MI, CAD, CHF, atrial fibrillation, pneumonia, or diabetes
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