

PCMH Quality Metrics Subcommittee Meeting  
September 15, 2014

Attendees

**Dr. Jonathan Griffin**, Chair, St. Peter's Hospital  
**Dr. Jeffrey Zavala**, St. Vincent's Hospital  
**Dr. Janice Gomersall**, Community Physicians Group, Mountain View Family Medicine and Obstetrics  
**Jody Haines**, Providence Health System  
**Jo Thompson**, Medicaid Division, Department of Public Health & Human Services  
**Mary LeMieux**, Medicaid Division, Department of Public Health & Human Services  
**Dustin Dickerson**, Medicaid Division  
**Eric Higginbotham**, Medicaid Division  
**Kelly Gallipeau**, Kalispell Regional Medical Center  
**Kristen Pete**, Glacier Medical Associates  
**Paula Block**, Montana Primary Care Association  
**Lisa Underwood**, Montana Primary Care Association  
**Dr. Rob Stenger**, St. Patrick's Hospital Grant Creek Family Practice  
**Dr. Thomas H. Roberts**, Montana Health Co-op  
**Kris Ingersoll**, Providence Health System  
**John Middleton**, St. Vincent's Hospital  
**Heather Senger**, St. Vincent's Hospital  
**Maggie Dunham**, St. Vincent's Hospital  
**Fred Stehler**, St. Vincent's Hospital  
**Janet Byers**, Providence Health System  
**Patty Estes**, Blue Cross Blue Shield of Montana  
**Erwin Austria**, BCBS of MT  
**Desa Osterhout**, BCBS of MT  
**Todd Harwell**, Public Health and Safety Division, Department of Public Health & Human Services  
**Dr. Steve Helgersen**, Public Health and Safety Division, Department of Public Health & Human Services  
**Janice Mackensen**, Mountain-Pacific Quality Health  
**Amy Everett**, St. Peter's Hospital  
**Jean Branscum**, MMA  
**Craig Hepp**, Billings Clinic  
**Cindy Haligan**  
**Scott Dufner**

CSI Staff

Christina Goe  
Amanda Eby  
Cathy Wright

CSI staff reported on conversations with national experts and other states about data reporting. They reported on the experiences of data collection of Michigan and Minnesota and evaluator perspectives from Bailit Health Purchasing and Harvard School of Public Health. Minnesota started their program collecting aggregate data and changed to patient-level data when they and their evaluators found the aggregate data to be very inadequate for evaluative purposes. They consulted with two different researchers who both told them that aggregate data did not produce results that could be evaluated and in fact could produce inaccurate results. Patient-level data was required for proper evaluation of PCMH programs.

Bailit Health Purchasing explained Pennsylvania's data reporting method that also includes patient-level data but instead of the government/program aggregating averages of data, the practices extract the patient-level specific data and used an IT platform that is built into that reported results to the program administrator on a uniform basis monthly.

The Harvard School of Public Health advocated for patient-level data reporting for accurate evaluations. Dr. Rosenthal emphasized that many states that have begun collecting patient-level data are now big advocates of this type of work in administration of a program. She reiterated that our difficulties are nothing that can't be overcome and especially by learning from other states' mistakes.

Michigan requires patient-level data and combines it with claims data in an all-payer, all-claims database to analyze overall health and utilization trends.

Dr. Griffin transitioned the meeting by asking for BCBS's perspective on data collection from the receiving side. BCBS found the main difficulty in aligning member level information because it is collected by different EHRs in different formats.

CSI and Dr. Griffin asked practices to explain their perspective on how they currently do PQRS reporting. Amy Emmert of St. Peter's hospital encouraged the program to stay on the path of alignment because having standards veer away from PQRS or Meaningful Use makes it very cumbersome. It is also more burdensome having a population defined for you to report on.

Kristen Pete of Glacier Medical Associates said that PQRS reporting is all based on claims and very different from the BCBS manual chart audit.

Janice Mackensen of Mountain Pacific Quality Health explained that there are many different methods and formats allowed for providers to report PQRS data, including external registry vendors.

Dr. Gomersall commented that all EHRs show data in different ways.

John Middleton of St. Vincent's explained the main struggles he has identified with data reporting: 1- incomplete data requests, not the same set to get a match; and 2- attestation method in EMRs constantly changing. He said the current guidance includes things they can find and match up easily in their EMRs.

CSI staff asked the attendees to transition the discussion from the PQRS to the draft reporting guidance for the state quality metrics. Staff asked attendees to consider and comment on what they thought reporting would be like for them with the guidance as it is. Staff asked the data staff from clinics to comment.

Paula Block of MPCA showed the guidance to her clinics. The larger community health centers (CHCs) think they can do it (even though they don't do PQRS reporting, they do UDS reporting instead). The small CHCs said they cannot do the reporting, in order to do it they would have to take resources away from patient care to run the reports. Lisa Underwood, also of MPCA said that many clinics have the ability to run the same reports on their EHRs that DPHHS is proposing to create so the reporting seems redundant.

Kelly Gallipeau of Kalispell Regional Medical center offered the clarification that if any of those small clinics received their NCQA accreditation under 2008 standards then they did not have to do quality reporting yet.

Jo Thompson of Medicaid offered the clarification that Medicaid will require the same data set BCBS is already requiring for PCMH contracts, including the patient-level data.

CSI staff asked for further comments from provider clinic data staff on the reporting guidance.

Dr. Stenger of Providence Health System responded that while most providers can do it, it is still building custom reports that requires considerable effort. He is consulting with his legal staff regarding a data sharing agreement for the data reporting. He is also concerned about the types of electronic format that will be required, i.e. what format of excel sheets.

Dr. Helgerson, state public health officer from DPHHS presented slides on the differences in how CSI could use data reported from clinics in aggregate form versus patient-level specific data.

Dr. Roberts asked if DPHHS/CSI would give advice to individual clinics on how to improve care. Dr. Helgerson responded that that one of the purposes of collecting the data would be to provide feedback to PCMHs in Montana. The feedback could identify groups of patients for whom quality improvement efforts were particularly indicated.

Providers expressed concern about DPHHS giving clinical direction to providers, there being no direct financial compensation for the reporting, and the reporting being very difficult.

CSI asked for suggestions on anything that could be done to adjust the guidance to make it any easier on providers.

Providers responded that there was nothing that could be done because it was too much work to do without payment and a potentially dangerous political move.

John Middleton commented that if the role and purpose of the data collection were explained better then the technical details would not be as difficult. In response, CSI staff explained the agency's role to

administer the program, provide sufficient, comprehensive oversight in a meaningful way that meets the obligations of anti-trust to allow for multiple payers to participate, and to implement uniform standards that make the PCMH delivery model a consistent experience for patients across the state. The purpose of data collection is to have meaningful data to be able to prove to the legislature and others that PCMH improves the health of Montanans and feed the data back to practices for them to use in their own practice improvement.

Amy Emmert commented that each individual organization needs to define their own steps they would need to take to improve their data. Dr. Helgerson responded that DPHHS programs offer to provide support to help care for patients with certain diagnoses, including hypertension, for example.

Dr. Roberts expressed concerns about the program over extending goals and authority. He advocated for aggregate data as a good step forward for the first year of the program.

Dr. Griffin offered that the MMA recommends the program stick with aggregate data in the first year and if the program requires patient-specific data initially, it could jeopardize the program.

CSI staff ended the meeting with plans to follow up with stakeholders on future meetings after internal discussions on how to move forward with data reporting.