Quality Metrics Subcommittee Meeting Summary
January 7, 2014

Attendees
Dr. Jonathon Griffin, St. Peter's Medical Group
Dr. Rob Stenger, Grant Creek Family Practice, Providence Medical Group
Dr. Janice Gomersall, Community Physicians Group, Mountain View Family Medicine and Obstetrics
Kristen Pete, Glacier Medical Associates
Todd Harwell, Montana Department of Public Health
Janice Mackensen, Mountain Pacific Quality Health Foundation
Paula Block, Montana Primary Care Association
Dr. Pat Morrow, BCBS of MT
Dr. Helgerson, Montana Department of Public Health
Craig Hepp, Billings Clinic
Anna Buckner, Montana Medicaid
Sherri Madzelonka, Practice Manager-Newton B. Coutinho MD PLLC

CSI Staff
Amanda Roccabruna Eby
Cathy Wright
Christina Goe

Since the last subcommittee meeting, CSI sent the four guidance documents to a variety of participants in the MT PCMH Program of different size and structure, and with different types of EMRs. The documents include: Draft Reporting Form, Quality Metric Reporting Guidance, Data Dictionary, and Sampling Strategy. CSI asked the practices to review the guidance documents and provide feedback. CSI distributed a document with the comments that had been submitted. The subcommittee went through each set of comments and then revisited each document. The guidance documents had not changed since the December council meeting.

The first comment discussed was from MPCA/Partnership Health Center and raised concerns regarding the childhood immunization measure and the ability to report refusal data. DPHHS suggested that sites on eClinical Works may have to choose this as the metric they don't report on in the first year. Kristen Pete offered some advice for how to run these reports with the additional data fields in eClincial Works and she offered to help other clinics learn how to do this. Dr. Morrow offered that clinics that can't report the "R" or "MC" should still do the metric with "Yes" or "No" data. The group agreed that since the refusals and medical contraindication data would be good to know, but shouldn't be a requirement that prevents clinics from reporting, clarifying language would be added for clinics to report the "R" or "MC" if able, but if not able then the "Yes" or "No" would be sufficient.

The next comment discussed was from Northwest Community Health Center in Libby and raised concerns about the 400 charts requested for the sampling strategy. There was some discussion about the NCQA requirements for sampling strategies and the amount of charts needed for statistical validity. Dr. Griffin commented that the sampling strategy should keep the number 400 for statistical validity and accurate data. The group decided that since they were uncertain how many clinics would even use the sampling strategy if they use an EMR rather than paper charts, CSI should survey program participants on their plans for reporting. The short survey should include questions about patient-level or attested data, EMR or paper charts, sample or all patients, and amount of patients. Amanda would have Dr.

Griffin and Paula Block review the questions before sending the survey to program participants the following week. Dr. Helgerson agreed to make Northwest CHC's suggested clarification to the tobacco cessation measure regarding whether or not a numerator and denominator is required.

Northwest CHC also recommended additional clarifying language for the childhood immunization measure: "and were 1st seen prior to their 3rd birthday." Dr. Gomersall proposed language for the immunization measure that her clinic uses to run self-reports. The subcommittee agreed with her proposed method and asked her to send it to Amanda to be added. Dr. Gomersall later submitted the following:

> *We look at all patients seen within the past 12 months who have achieved their 2nd birthday but not yet their third birthday. We look at the required immunizations (which for us does not include rotavirus but does include four DTaP, four Prevnar, four Hib, three IPV, three Hep B, two Hep A, two varicella, and one MMR.). There is some argument about 1 or 2 varicella and rotavirus, but likely will be as mentioned above.*

The next comments discussed were from Bozeman Deaconess Health Group. Amanda had already answered their question about the defined PCMH patient population. They asked about the proposed method of electronic submission of data and the defined format. The subcommittee agreed that additional instructions need to be added to the guidance on the standard format and how to submit the data through the state's secure file transfer service. Bozeman also asked about the March reporting timeline and similar reports they will be running in February. DPHHS proposed a two week grace period. The subcommittee agreed that a two-week grace period should not be announced and only allowed on a case by case basis, for cause, at the Commissioner's discretion.

Bozeman Deaconess recommended changing the sampling strategy instructions to say "must" rather than "should" consult with CSI to confirm an alternate sample method prior to submitting the report. The subcommittee agreed with this change.

An anonymous practice asked about the reporting time frame. The subcommittee agreed that the guidance clearly stated calendar year 2014, with the measure established at the time of the last outpatient visit during 2014. The practice asked if it would suffice to submit Meaningful Use reports. The subcommittee agreed with DPHHS's response that no, the denominator of interest for the PCMH report is the patient population and it would be too complicated to try to aggregate individual provider reports and confirm that all patients were included and none were counted more than once.

These suggestions can be considered by the stakeholder council and CSI for the 2016 report, but no additional measures can be considered for the 2015 report. Reporting measures are set in rule, changing them now is not possible. More can be added later, if the stakeholders recommend them.

The last comments discussed came from Newton B. Coutinho MD PLLC's clinic and included questions about the ICD9 vs. ICD10 codes as well as tobacco use diagnosis codes. The subcommittee agreed that most providers are still on ICD9 and that's what the guidance should be. Providers discussed using structured data fields or social history screening narrative rather than ICD or CPT codes to collect/report tobacco use data. Dr. Stenger acknowledged that the guidance assumes that providers are screening all patients for tobacco use and proposed clarifying language that he would email to Amanda to be incorporated.

The subcommittee went back through each of the four guidance documents and reviewed the edits that needed to be made, asking for final edits. On the Data Reporting Form, #5 did not need to be listed for each measure, once at the top of the form would suffice. The subcommittee reached consensus to recommend the guidance documents to the council for approval, as amended based on the discussion.

CSI staff asked the subcommittee for suggestions for specific deliverables and tasks to go into a scope of work proposal for the consultant being pursued via RWJF technical assistance. Suggestions included projects to improve health; advise on data analysis and submission methods; help with a mental health measure; a collaboration with providers for early data submission; advise on data sharing agreements; help to make data valuable to everyone; guidance in setting state benchmarks; and coordination between PCMHs, hospitals and other health providers to reduce costs.