PCMH Quality Metrics Subcommittee
Meeting Summary
May 11, 2016

Attendees
Dr. Rob Stenger, Partnership Health Center
Dr. Janice Gomersall, Community Physicians Group
Kristen Schuster, Glacier Medical Associates
Jan Bechtold, Billings Clinic
Mary LeMieux, Montana Medicaid
Todd Harwell, MT DPHHS- Public Health and Safety Division Administrator
Kathy Myers, MT DPHHS- Chronic Disease Prevention and Health Promotion Bureau
Scott Malloy, Montana Healthcare Foundation
Erwin Austria, Blue Cross Blue Shield of Montana
Desa Osterhout, Blue Cross Blue Shield of Montana

CSI Staff
Amanda Roccabruna Eby
Catherine Wright
Christina Goe

The meeting included a report on the data received, how the data cleaning process had went for CSI staff, the current status of the data analysis, and the timeline going forward. There were 38 clinics that reported aggregate (option 2) and 23 clinics that reported patient-level (option 1) data. Below are the anomalies found in the data by CSI staff and the clinics follow-up they did. CSI made the appropriate corrections to the data files based on the clinics' instructions and documented all changes made to data.

Data Findings
Diabetes
- 5 or more clinics had more than 5% blank entries for both the A1c and the date of the A1c. CSI contacted these clinics to verify whether these patients were seen in 2015 and did not get an A1c measurement or if they were not seen in 2015.

Hypertension
- 5 or more clinics had more than 5% blank entries for both the BP value and the date of the BP. CSI contacted these clinics to verify whether these patients were seen in 2015 and did not get a BP measurement or if they were not seen in 2015.

Immunizations
- 5 clinics had patients with an "N" indicated for all doses of an immunization received, yet a date administered was entered for the last does of the series. CSI removed the dates based on clinic instructions. 1 clinic had missing "Y" or "N" values.

Tobacco
- 1 clinic had many patients who screened negative for tobacco but had a "Y" entered for cessation intervention and had an intervention date. CSI found that this was due to a miscommunication in a clinic that was providing tobacco education to all patients regardless of whether or not they were users and documenting it as cessation intervention. CSI removed the "Y" and date for cessation intervention as instructed by the clinic.

- 5 clinics had discrepancies between patients that had positive screens and incomplete information given for the cessation intervention or negative screens and inaccurate information given for the cessation intervention. CSI found that this was largely due to a health system's EMR change mid-year.

Depression

- 10 clinics submitted patient-level depression data, 16 submitted aggregate

- 8 clinics have a workflow/data collection process that makes their data skewed from the others. They had patients who screened negative for depression but had a "yes" and a date for follow-up plan because they are documenting the PHQ9 as the follow-up plan given to patients even after they don't screen positive from the PHQ2 (the first 2 questions of the PHQ9) during intake. PQRS lists "additional evaluation" as the first option for a follow-up plan, based on that, the PHQ9 could be accepted as a follow-up plan. HRSA directs CHCs to count the PHQ9 as a follow-up plan for UDS reporting. Analysts will address the issue by only counting the patients who screened positive in the numerator when calculating percentage rates.

Timeline

- CSI moved the BP and A1c data over to the epidemiologists' shared drive on May 6th. The immunizations and tobacco data was moved over on May 16th and the depression data on May 17th. Clinic follow-up continues to be done by CSI as the epidemiologists communicate additional data anomalies found to CSI staff.
- The epis will complete analysis of the data and tables for the Commissioner's public report by June 10th. There will be 4 less tables this year because there was not data collected on rate of documented hypertension, rate of documented diabetes, or number of tobacco users. The rates for aggregate and patient-level can be in one table, with two bars.
- The Commissioner releases 2016 public report on Thursday, June 30th.

Additional Discussion

CSI reported that in addition to the anomalies with the patient-level tobacco data, the tobacco rates are all over leading analysts to believe the data was possibly pulled improperly by some clinics. Attendees thought this measure in particular needs to be considered by the subcommittee at future meetings for improvement in clarity. If the cessation intervention rates are high but use rates aren't going down then there is a different public health issue with how cessation is provided. Todd Harwell commented that tobacco is still the leading cause of disease and death in the US and Montana so it should not be removed. Different patient populations could be causing the variance in the rates. Other providers commented that it is too easy for some providers to simply check a box for cessation and not necessarily provide an effective intervention.

The group discussed the challenges with the depression screening data. CSI and public health staff need to find a national estimate and target for the measure as well as recommendations on the measure for the feedback reports to clinics. Todd Harwell recommended checking with NQF or NCQA for aggregate rates or recommendations, CMS may also have benchmarks in coordination with the PQRS metric. He also suggested asking Mathematica for a recommendation.

CSI relayed to the group challenges some clinics are having with pulling patient-level data according to the specifications due to limitations with their EMR. Kristen commented that while she has limitations with eCW pulling patients into categories but not with all the required data elements, she is then able to

do manual extraction for what is missing. Janice suggested creating learning networks organized by clinics on the same EHRs. Kristen replied that she presented on a webinar organized by Patty Kosednar at Health Technology Services for all PCMHs on eCW and only about three of the sixteen or more clinics on eCW attended the webinar. Resources and assistance have been available to clinics but many are not using it. Some attendees commented that if clinics are not able to report data then they may not be able to stay in the program because PCMH is about more than just transforming care delivery, it is entire practice transformation, including data reporting. CSI reminded the group that they will work with practices and help them however they can with data reporting challenges.