PCMH Quality Metrics Subcommittee Meeting Materials – 6/8/2016

AGENDA ITEM #3 - Discuss confusion with depression and tobacco measures

The following clarification was emailed to all clinics that submitted aggregate tobacco and aggregate depression data, including flow charts illustrating the correct data pull for each:

The tobacco **denominator** should be the following:

- Total number of patients aged 18 and older who had a visit in the calendar year of 2015

The tobacco **numerator** should be the **sum** of the following two numbers:

1. Total number of patients in the denominator population who were screened for tobacco use at least once within 24 months AND were identified as a tobacco user AND received cessation counseling intervention
2. Total number of patients in the denominator population who were screened for tobacco use at least once within 24 months AND were identified as a **non-tobacco** user (Click here for flow chart)

The depression **denominator** should be the following:

- Total number of patients aged 12 and older who had a visit in the calendar year of 2015

The depression **numerator** should be the **sum** of the following two numbers:

1. Total number of patients in the denominator population who were screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND screened positive AND a follow-up plan is documented on the date of the positive screen
2. Total number of patients in the denominator population who were screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND screened **negative** (Click here for flow chart)

AGENDA ITEM #4 - Discuss CMS/NQF standards that have version changes

1. Controlling high blood pressure – last year was CMS 165 V3, is now CMS 165 V4: https://ecqi.healthit.gov/ep/2014-measures-2015-update/controlling-high-blood-pressure
2. Tobacco Use Screening & Cessation – last year was CMS 138 V3, is now CMS 138 V4: https://ecqi.healthit.gov/eh/2014-measures-2015-update/preventive-care-and-screening-tobacco-use-screening-and-cessation
3. Diabetes Hemoglobin A1c Poor Control – last year was CMS 122 V3, is now CMS 122 V4: https://ecqi.healthit.gov/eh/2014-measures-2015-update/diabetes-hemoglobin-a1c-poor-control
4. Screening for Clinical Depression – last year was CMS 2 V4, is now CMS 2 V5: https://ecqi.healthit.gov/eh/2014-measures-2015-update/preventive-care-and-screening-screening-clinical-depression-and-follow

AGENDA ITEM #5 - Discuss PQRS vs. CSI patient-level detail reporting differences

1. PQRS does require patient level detail (each method has different requirements for # of patients you need to report on, and you only HAVE to report on Medicare beneficiaries for most of the methods). For most measures PQRS requires the following information on each patient in the measure denominator:
    a. Patient ID
    b. Race
    c. Ethnicity

d. Gender
e. Payor
f. If the patient meets the performance criteria of the measure (if yes, they will be included in the numerator)

2. Contrary to the Montana PCMH program reporting requirements, the patient-level detail for PQRS **does not** require any of the following information to be submitted (except for organizations submitting data via GPRO Web Interface which is only available for organizations with 25 or more providers, but they do not have to choose this method):
    a. HTN Blood Pressure (CMS 165/PQRS 236)
        i. Date of most recent blood pressure reading
        ii. Systolic blood pressure measure
        iii. Diastolic blood pressure measure
        iv. (see "supplemental data elements" on the attached spec to confirm - https://ecqi.healthit.gov/system/files/ecqm/2014/EP/measures/CMS165v4_2.html)
    b. Tobacco Use Screening and Cessation Intervention (CMS 138/PQRS 226)
        i. If the patient is a current tobacco user
        ii. Date of cessation intervention
        iii. (see "supplemental data elements" on the attached spec to confirm - https://ecqi.healthit.gov/system/files/ecqm/2014/EP/measures/CMS138v4_2.html)
    c. Diabetes A1c Poor Control (CMS 122/PQRS 001)
        i. Date A1c measured
        ii. A1c level
        iii. (see "supplemental data elements" on the attached spec to confirm - https://ecqi.healthit.gov/system/files/ecqm/2014/EP/measures/CMS122v4_2.html)
    d. Screening for Clinical Depression and Follow Up Plan (CMS 2/PQRS 134)
        i. Date of positive screening
        ii. (see "supplemental data elements" on the attached spec to confirm - https://ecqi.healthit.gov/system/files/ecqm/2014/EP/measures/CMS2v5_3.html)
3. For clinics reporting PQRS directly out of their EHRs, they are required to submit the information in a QRDA (quality reporting data architecture) format. Those reports will also not have the data identified in section 2 above, but will have the following patient level data for each patient in the denominator:
    a. Patient ID
    b. Name (first and last)
    c. Address
    d. City
    e. State
    f. Zip
    g. Country
    h. Birth Date
    i. Race
    j. Ethnicity
    k. Gender
    l. Payor