

Montana PCMH Program 2015 Quality Metric Data Feedback Webinar

September 19, 2016

12:00 – 1:30 pm

Montana Commissioner of Insurance and Securities

Webinar Agenda

1. Highlights from Montana PCMH Program Year 2 (CSI staff)
2. Overview of clinic feedback reports and explanation of data analysis
(Carrie Oser of DPHHS Chronic Disease Prevention Bureau)
3. Opportunities to work with clinics on clinical quality improvement
(DPHHS– Kathy Myers and Carrie Oser)
4. How HTS can help PCMHs – electronic clinical quality improvement projects (eCQI)
(Health Technology Services – Patty Kosednar)
5. Results from PCMH clinics currently participating in eCQI projects (Patty Kosednar)
6. Testimonial – Kalispell Regional Healthcare Woodland Clinic
7. Brief preview of 2017 Quality Metric Reporting Guidance (CSI staff)

Kathy Myers

Kathy Myers RN, BSN is currently the Chief of the Chronic Disease Prevention and Health Promotion Bureau which resides in the Public Health and Safety Division of the Department of Health and Human Services. Kathy was previously the Montana Cancer Control Programs Section Supervisor.

Patty Kosednar

Patty is the Executive Director for Health Technology Services. Patty has been with Health Technology Services, the MT/WY Regional Extension Center for 5 years providing Health Technology Consulting, E.H.R Implementation, Meaningful Use Consulting, HIT Quality Improvement and Project Management to clients throughout Montana and Wyoming. She has been an IT/Project Management Professional for 26 years. Patty is a certified Project Management Professional (PMP) and an E.H.R certified Professional and received a certification in Nonprofit Administration from the University of Montana.

Program Participation

- There were three new Montana clinics provisionally-qualified as PCMHs in 2015;
- Since then, one of those three became qualified when they received NCQA PCMH recognition in March 2016 and the other two expect to receive their NCQA recognition in October 2016.
- As of today there are 62 qualified PCMHs and 7 provisionally qualified PCMHs

Montana PCMH Program Year 2

- Year 2 quality metric rates are comparable to last year's rates and is generally above national averages.
- Some of the change in rates can be attributed to improvement in data extraction by PCMHs.
- Improvement in data tracking is important progress, even if small, because data is a critical component to the complete practice transformation that occurs in PCMH implementation.

PCMH Strengths & Progress

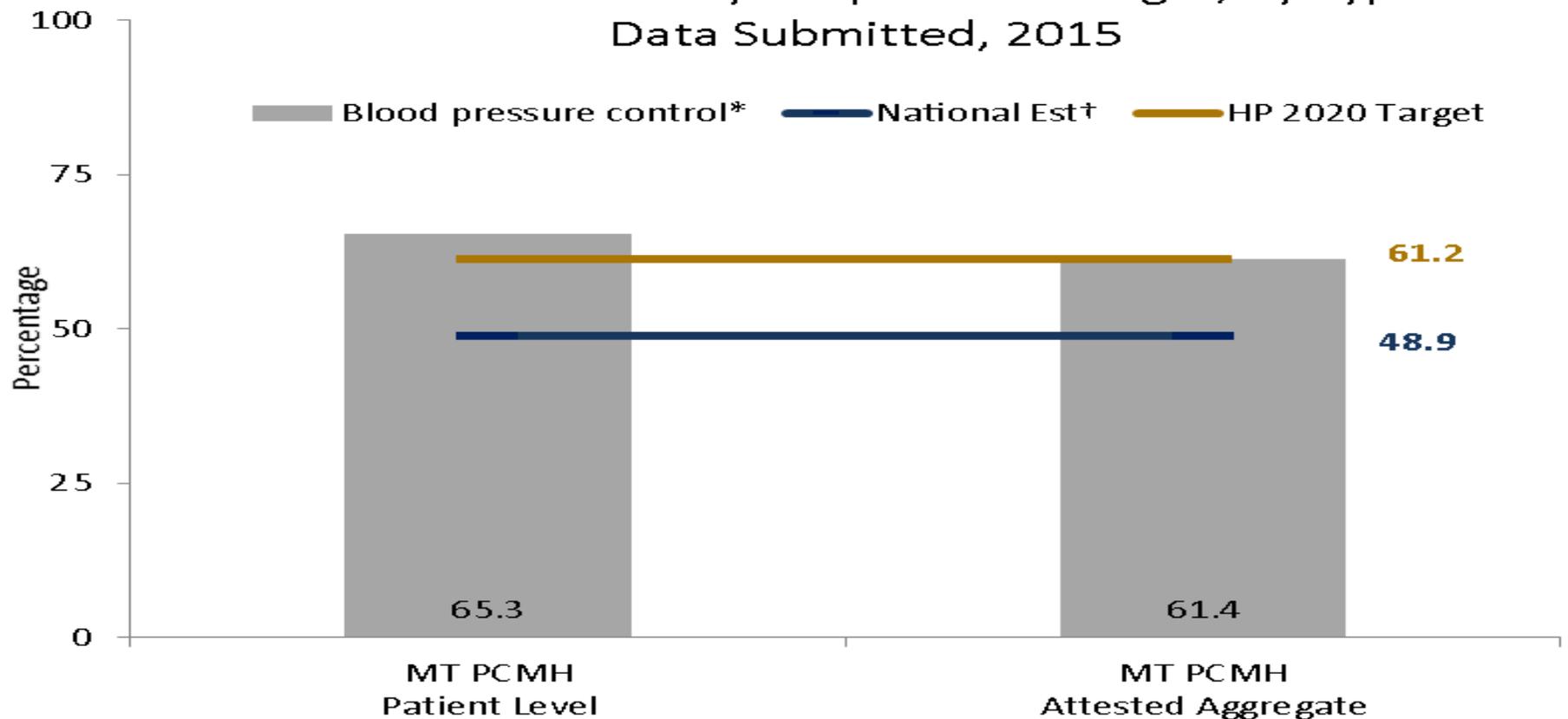
- Montana PCMHs have a better blood pressure control rate for hypertension patients. Better than Healthy People 2020 Target for two years in a row.
- PCMHs have a higher depression screening rate than the national estimate.

PCMH Progress

- HTS and DPHHS have recruited and worked with twenty-seven PCMH clinics on data technical assistance and clinical quality improvement.
- Clinics receiving this assistance are working on tracking 2016 data and improving their workflows, mainly with diabetes and hypertension patients.
- Patient-engagement, education and self-management tools are the key to improving the health of patients with these chronic diseases.
 - For instance, a common practice of PCMH clinics is loaning blood pressure cuffs to patients with hypertension, which increases patient awareness and promotes self-management.

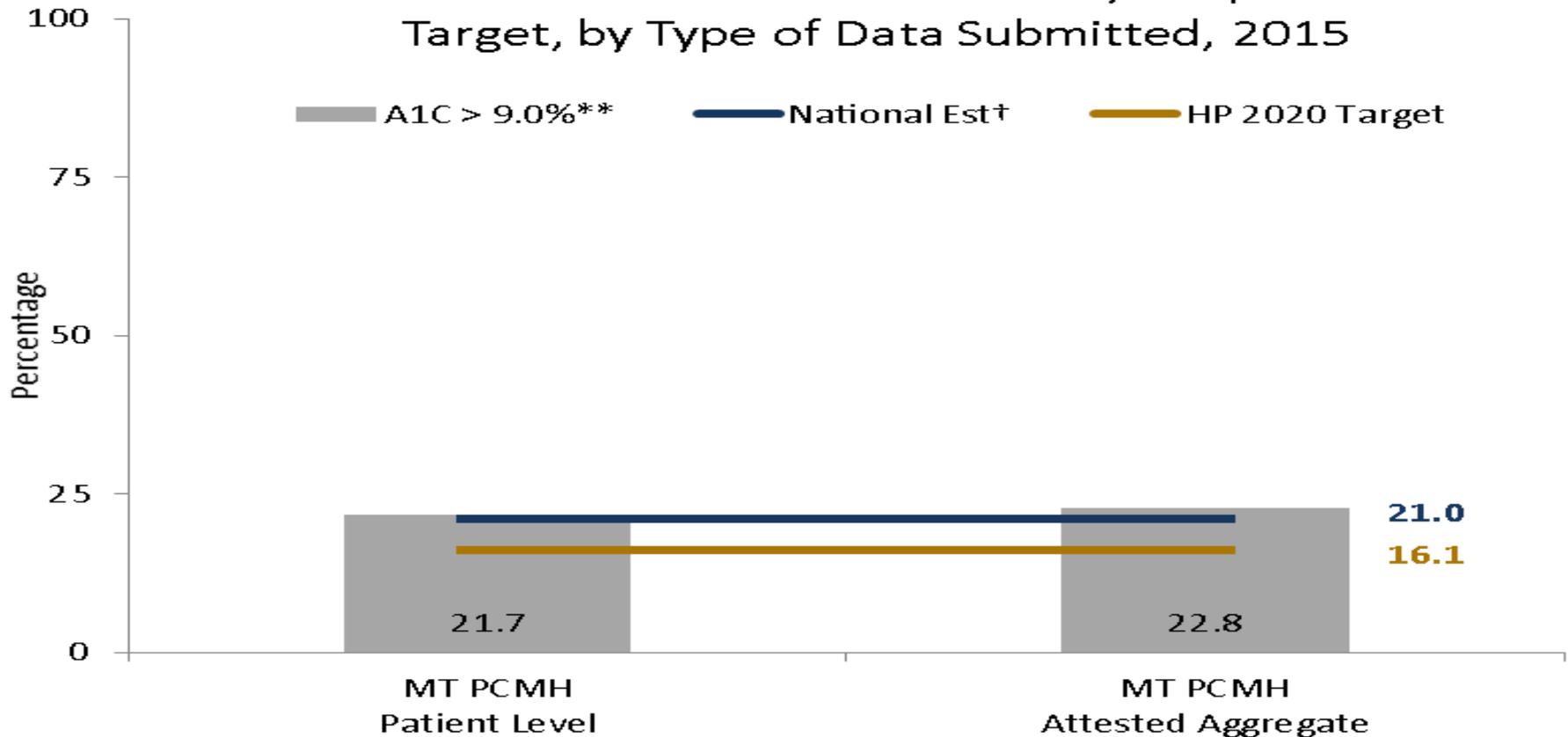
PCMH Blood Pressure Control

Documented Blood Pressure Control Rate among Montana PCMH Clinics Compared to the National Estimate and Healthy People 2020 Target, by Type of Data Submitted, 2015



PCMH Diabetes Control

Documented Rate of A1C >9.0% for Patients with Diabetes among Montana PCMH Clinics Compared to the National Estimate and Healthy People 2020 Target, by Type of Data Submitted, 2015



PCMH Depression Screening

- PCMH clinics in Montana also have a higher depression screening rate than the national estimate.
- Clinics are working with HTS/DPHHS to
 - establish or improve workflows for depression screening; and
 - improve their data collection and tracking process.
- In some geographic service areas, there is still a lack of qualified mental health professionals, making follow up treatment difficult for some areas;
- Recommendations for filling this gap include the development of relationships with regional mental health professionals, mental health telemedicine services, and other remote consultation mental health services.

Other Year 2 Highlights

- Increases in PCMHs offering same day appointments, a patient portal, and expanded office hours
- Increases in PCMHs that collaborate and assist patients in personal goals for their improved health (self-management and goal setting)
- 46% have primary care related integrated behavioral health services
- 81% have care coordinators/managers or patient navigators
- 43% have a certified diabetes educator
- 31% have a dietician
- 50% have a clinical pharmacist
- 78% are receiving enhanced PCMH reimbursement from a payor, up from 56% in Year 1
 - Unfortunately, the majority of those clinics reported that they only receive enhanced reimbursement for up to 10% of their patient population

St. V's Absarokee Patient Story

53 years old male – smoker and type 2 diabetic

- Responded to “Readiness to Quit” tobacco letter that was sent to all tobacco users, met with PCP and developed plan to quit with quit line and kit
- Utilized integrated behavioral health services for coaching and monitoring progress
- Diabetic Educator monthly visits via telemedicine
- Patient responded to letter stating he was due for Hgb A1c repeat
 - Hgb A1c went from 11.6% to 6% in a 6 month period.
 - Estimated average glucose went from 295 to 126 mg/dL



Montana
Chronic Disease Prevention
& Health Promotion Bureau

Data Submission

- 60 PCHMs submitted data.
 - 37 provided attested aggregate-level
 - 23 provided patient-level
- Provided a good sample size
- Data quality

Data Submission - Guidance

Variable Name	Reporting definition
Sex	M (for male) or F (for female)
Date of birth	MMDDYYYY (month, numeric, 2 digits) (day, numeric, 2 digits) (year, numeric, 4 digits)
Date quality measure was measured (bp measured; cessation counseling provided; immunization administered, A1c measured, positive depression screening)	MMDDYYYY (month, numeric, 2 digits) (day, numeric, 2 digits) (year, numeric, 4 digits)
SBP (systolic blood pressure)	(numeric, 3 digits for systolic)
DBP (diastolic blood pressure)	(numeric, 3 digits for diastolic)
A1C	(numeric, 2 digits followed by a decimal followed by 1 digit)

Data Submission - Guidance

Variable Name	Reporting definition
TUS (Current tobacco user)	Y (Yes if current tobacco user) N (No if not current tobacco user)
TUCI (If tobacco user, cessation intervention)	Y (Yes if intervention provided) N (No if intervention not provided)
Each childhood immunization measure	Y (Yes if immunization has been provided) N (No if immunization has not been provided) MC (Medical contraindication) R (Refusal to be vaccinated)
PSN (Positive depression screening)	Y (Yes if depression screen positive) N (No if depression screen negative)
FUP (Follow-up depression plan documented)	Y (Yes if follow-up plan documented) N (No if follow-up plan not documented)

Data Submission-Challenges

- Data from previous years
- Data submitted in a different format
- Data submitted with a 'test date' but no test results reported
- Error reporting blood pressure and A1c values
- Incomplete data submission

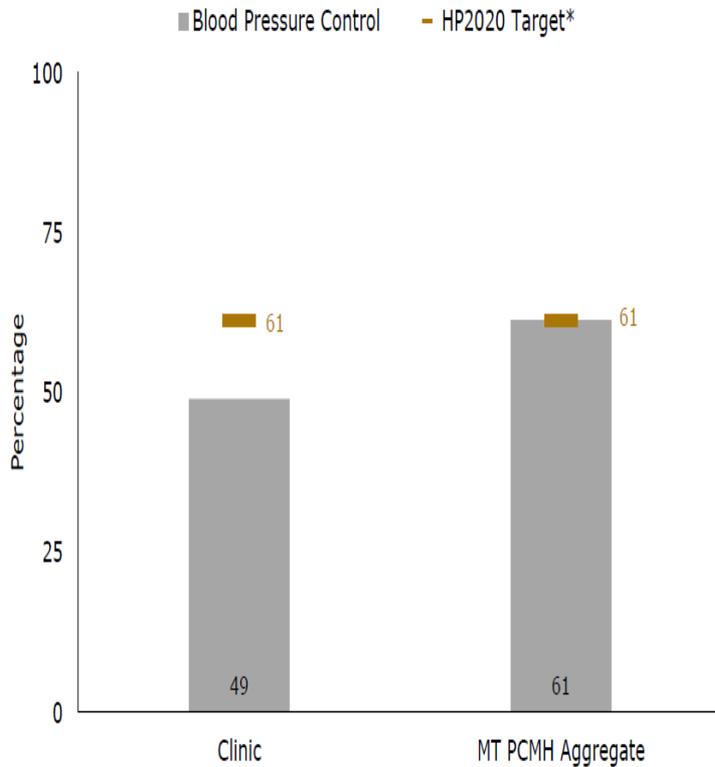
Controlling High Blood Pressure



Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled ($< 140/90$ mmHg) and who had a visit during the measurement period of calendar year 2015

ATTESTED AGGREGATE

Figure 1. Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) and who had a visit during the measurement period of calendar year 2015.



*HP2020 Target: *Healthy People* provides science-based, 10-year national objectives for improving the health of all Americans.

PATIENT LEVEL

Figure 1. Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) and who had a visit during the measurement period of calendar year 2015.

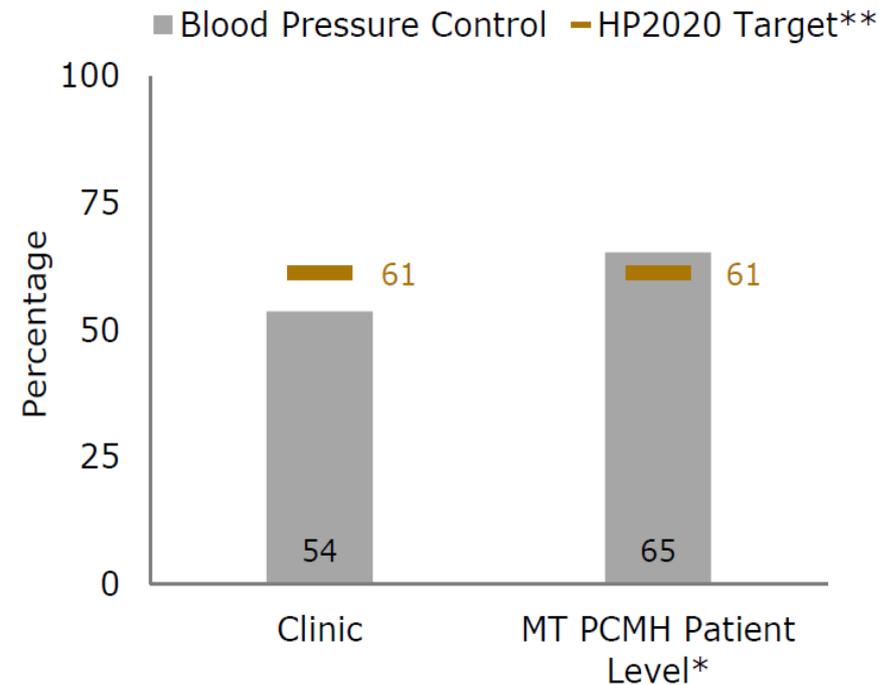


Figure 2. Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) and who had a visit during the measurement period of calendar year 2015, **by sex.**

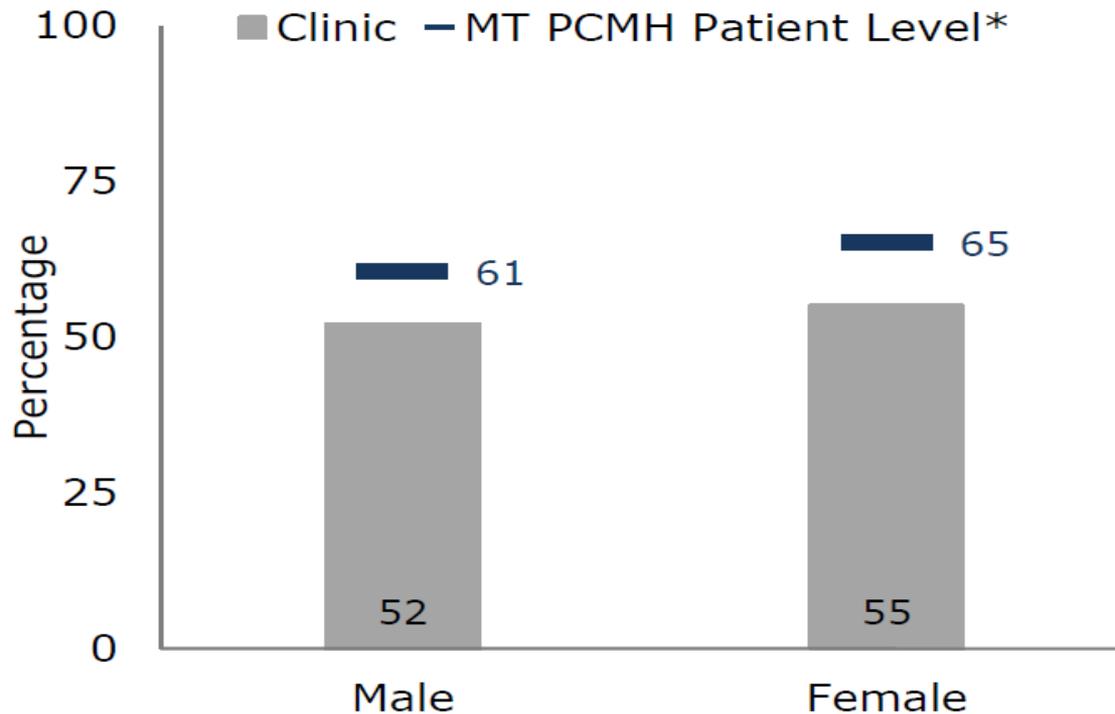
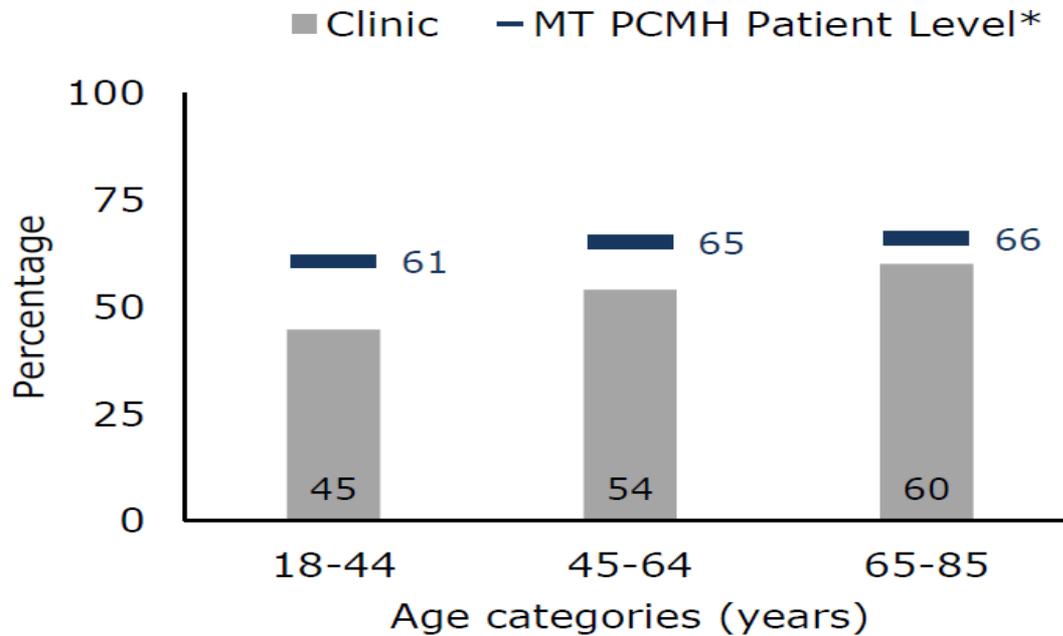


Figure 3. Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) and who had a visit during the measurement period of calendar year 2015, **by age.**

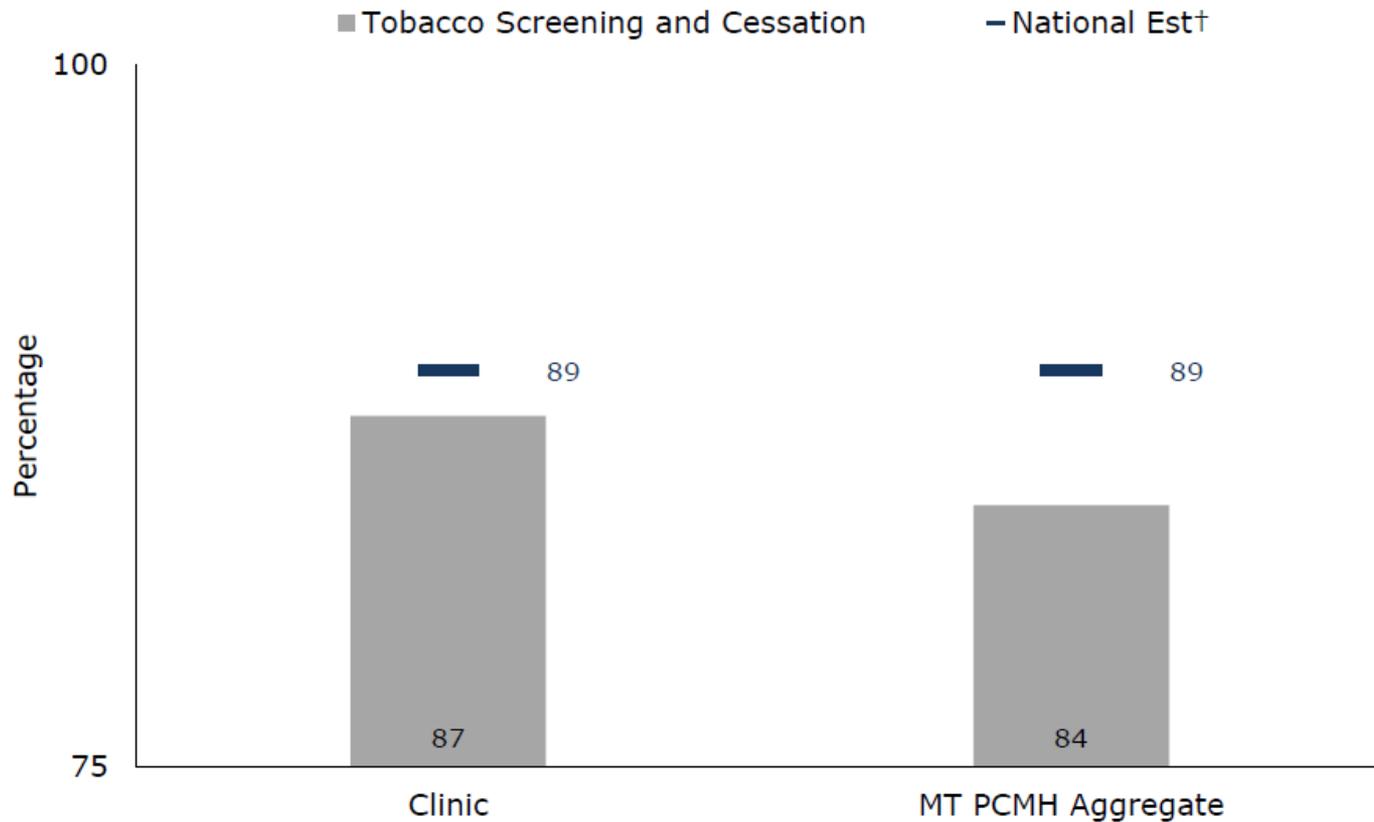


Tobacco Use: Screening and Cessation Intervention



Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user

Figure 2. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user.



†Data source: CMS Benchmarks for Measures Included in the Performance Year 2015 Quality and Resource Use Reports.

Figure 5. Percentage of patients aged 18 years and older who were documented tobacco users and the percentage of tobacco users who received cessation intervention, **by sex.**

- Clinic tobacco user
- ▨ Clinic tobacco user receiving cessation
- All patient level tobacco users
- All patient level tobacco users receiving cessation

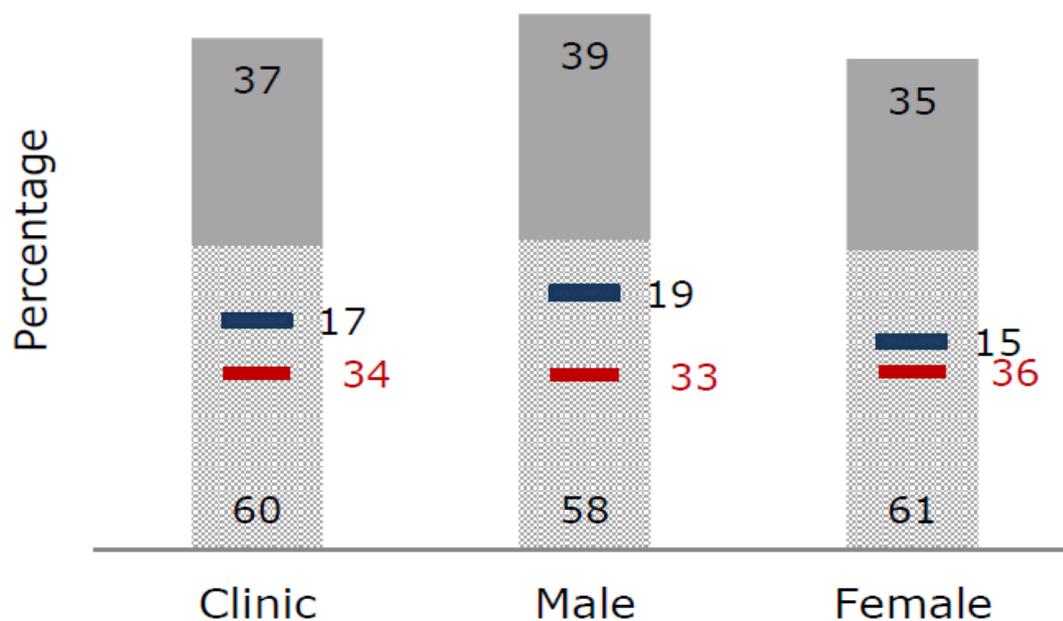
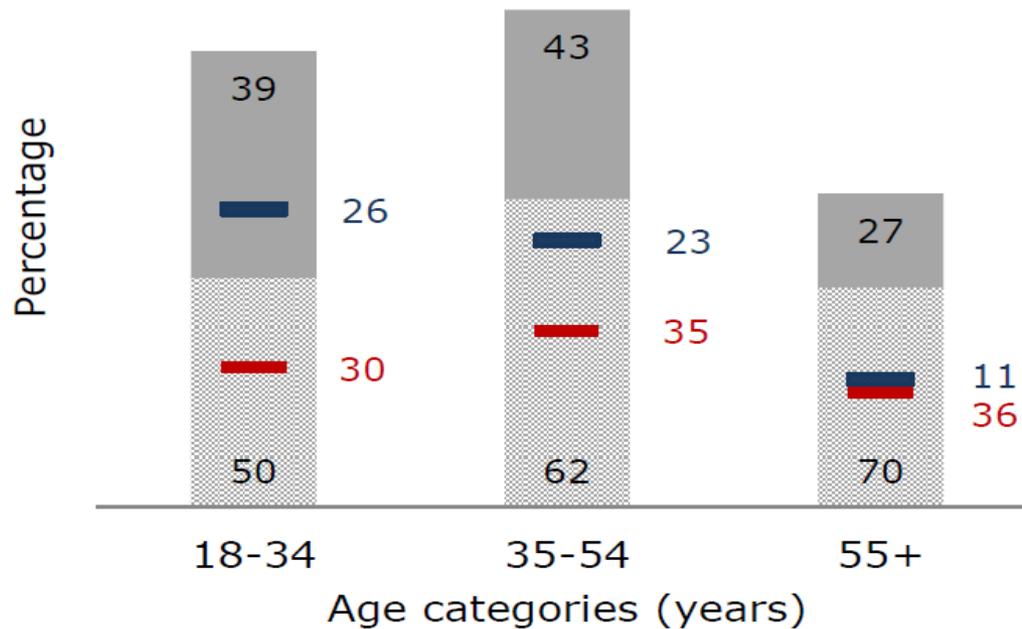


Figure 6. Percentage of patients aged 18 years and older who were documented tobacco users and the percentage of tobacco users who received cessation intervention, **by age.**

- Clinic tobacco user
- ▨ Clinic tobacco user receiving cessation
- All patient level tobacco users
- All patient level tobacco users receiving cessation

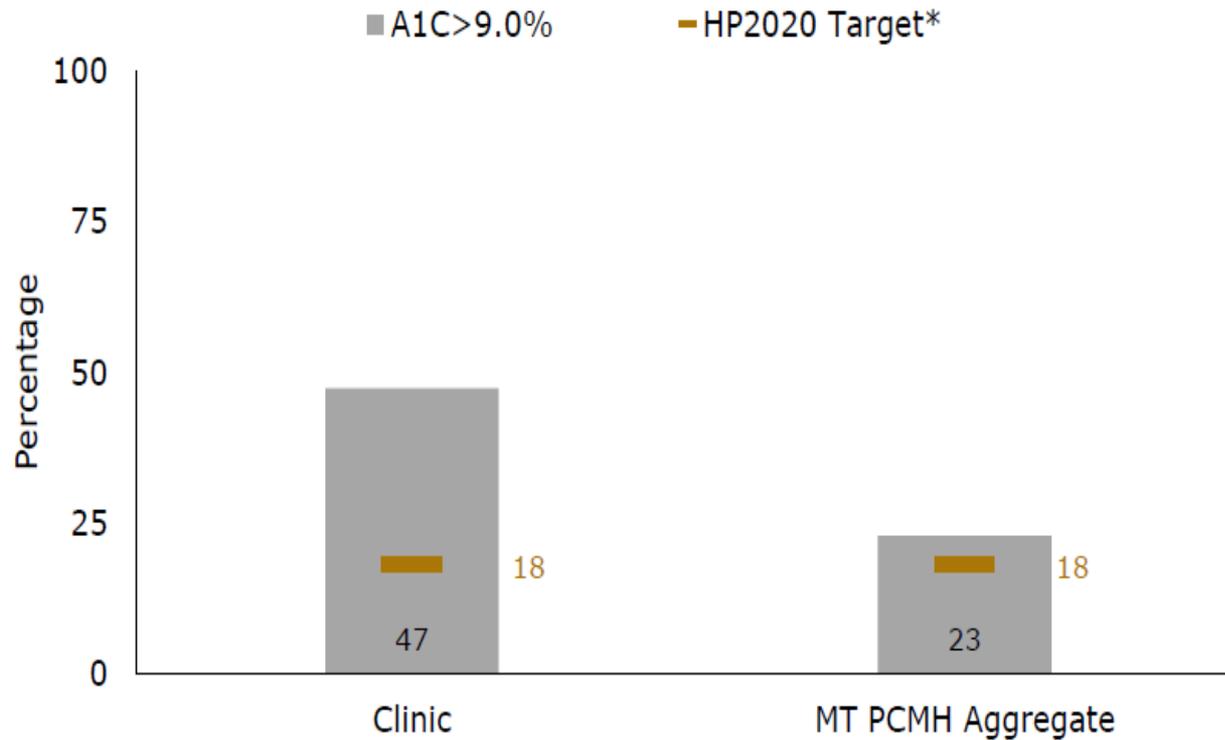


Diabetes: Hemoglobin A1c Poor Control



Percentage of patients 18 through 75 years of age with diabetes who had hemoglobin A1c > 9.0% and had a visit during the measurement period of calendar year 2015

Figure 3. Percentage of patients 18 through 75 years of age with diabetes who had hemoglobin A1c > 9.0% and had a visit during the measurement period of calendar year 2015.



*HP2020 Target: *Healthy People* provides science-based, 10-year national objectives for improving the health of all Americans.

Figure 8. Percentage of patients 18 through 75 years of age with diabetes who had hemoglobin A1c > 9.0% and had a visit during the measurement period of calendar year 2015, **by sex.**

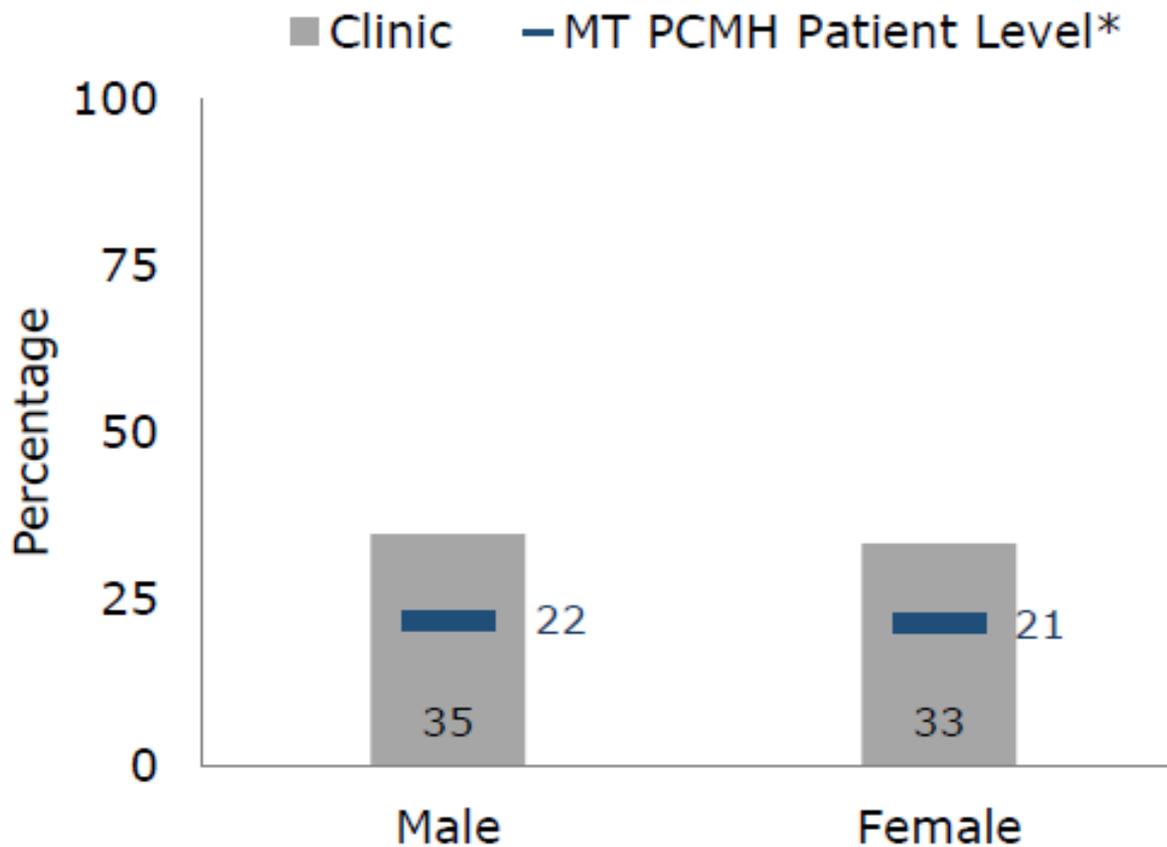
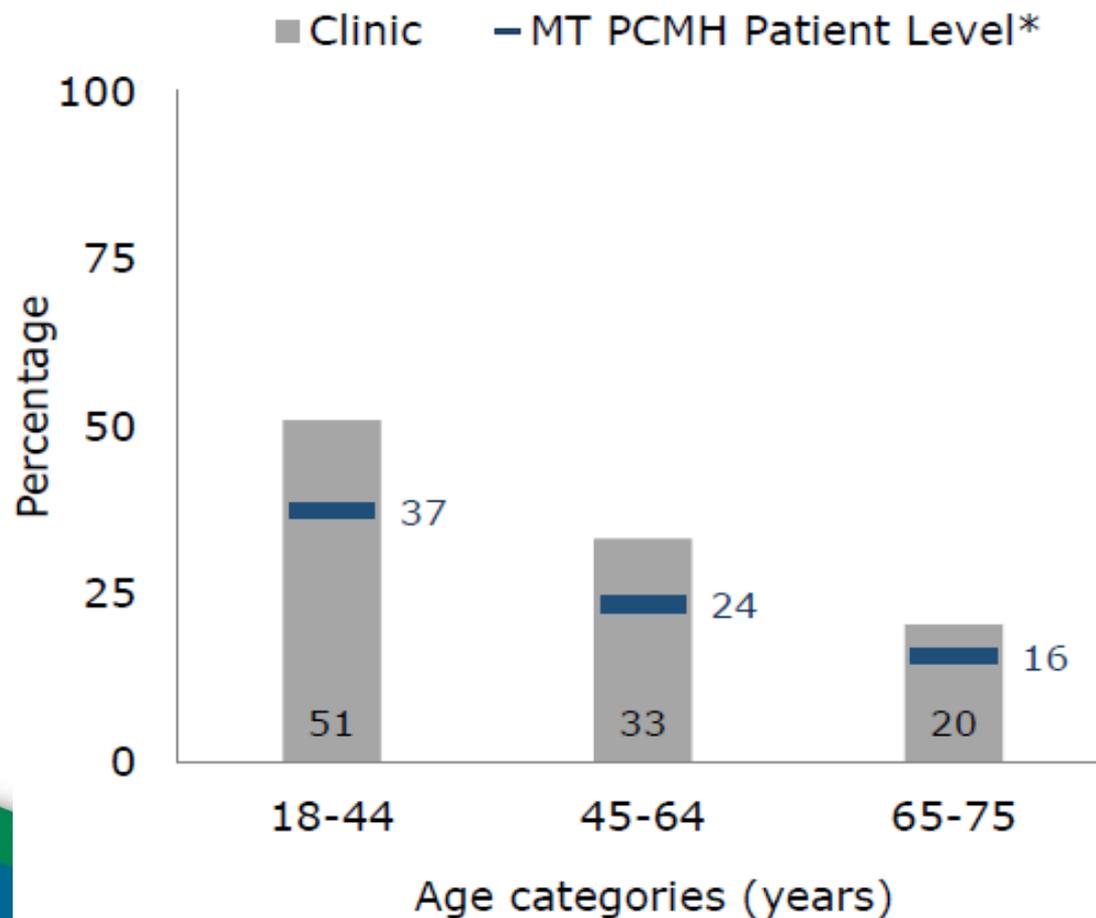


Figure 9. Percentage of patients 18 through 75 years of age with diabetes who had hemoglobin A1c > 9.0% and had a visit during the measurement period of calendar year 2015, by age.

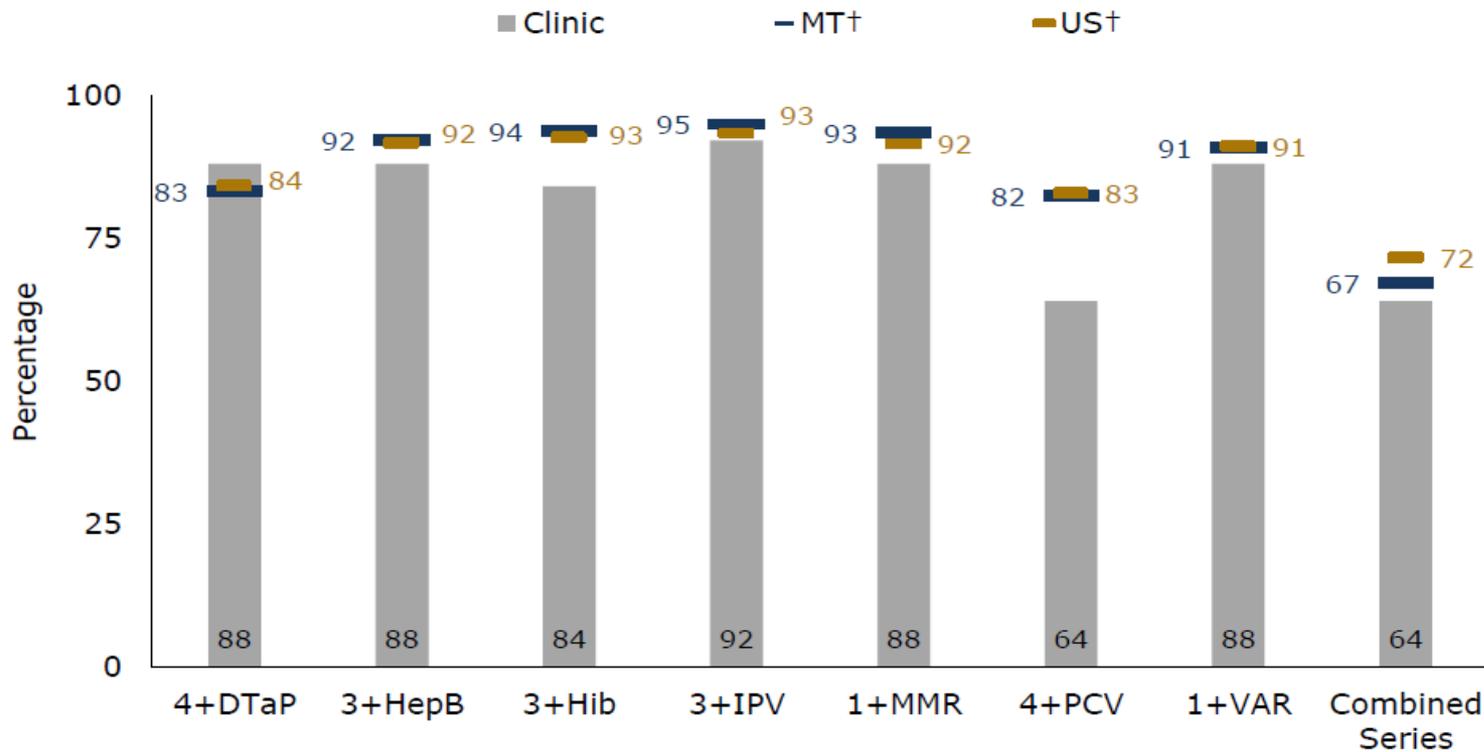


Rate of Fully Immunized 3 Year Old Children



Percentage of children with their 3rd birthday during the measurement period of calendar year 2015 who were fully immunized before their 3rd birthday

Figure 4. Percentage of children with their 3rd birthday during the measurement period of calendar year 2015 who were fully immunized before their 3rd birthday.

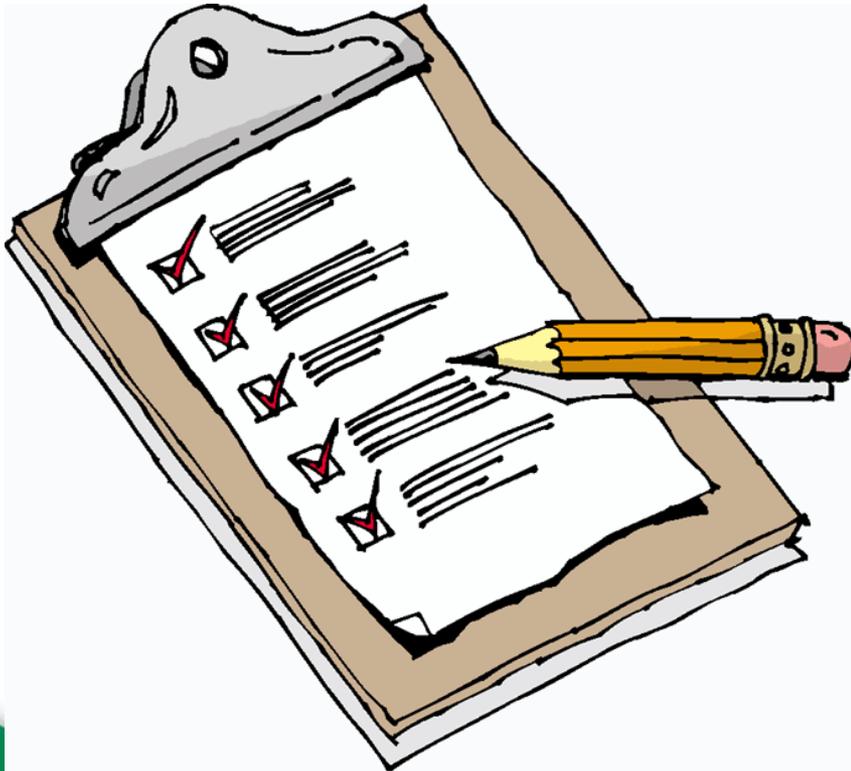


DTaP = diphtheria and tetanus toxoids and acellular pertussis vaccine; HepB = hepatitis B vaccine; Hib = *Haemophilus influenzae* type B conjugate vaccine; IPV = inactivated poliovirus vaccine; MMR = measles, mumps, and rubella vaccine; PCV = pneumococcal vaccine; VAR = varicella vaccine.

[†]Data from National Immunization Survey (NIS); estimated immunization coverage for children aged 19–35 months during 2014.

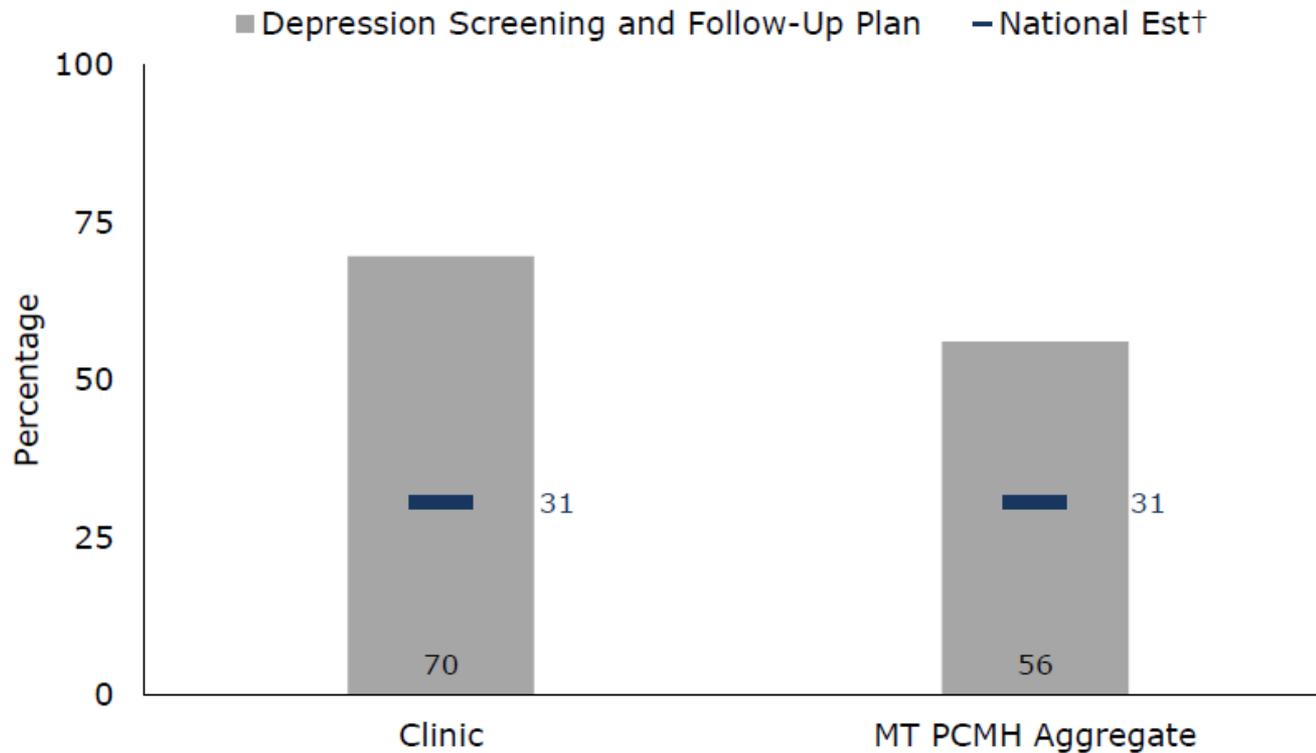
[§]Combined series (4:3:1:3:3:1:4) includes ≥4 doses of DTaP, ≥3 doses of IPV, ≥1 dose of MMR, full series of Hib (≥3 doses for PCMH data, 3 or 4 doses for NIS depending on product type), ≥3 doses of HepB, ≥1 dose of VAR, and ≥4 doses of PCV.

Screening for Clinical Depression and Follow-up Plan



Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

Figure 5. Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.



†Data Source: CMS Benchmarks For Measures Included in the Performance Year 2015 Quality and Resource Use Reports.

Figure 12. Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen, **by sex.**

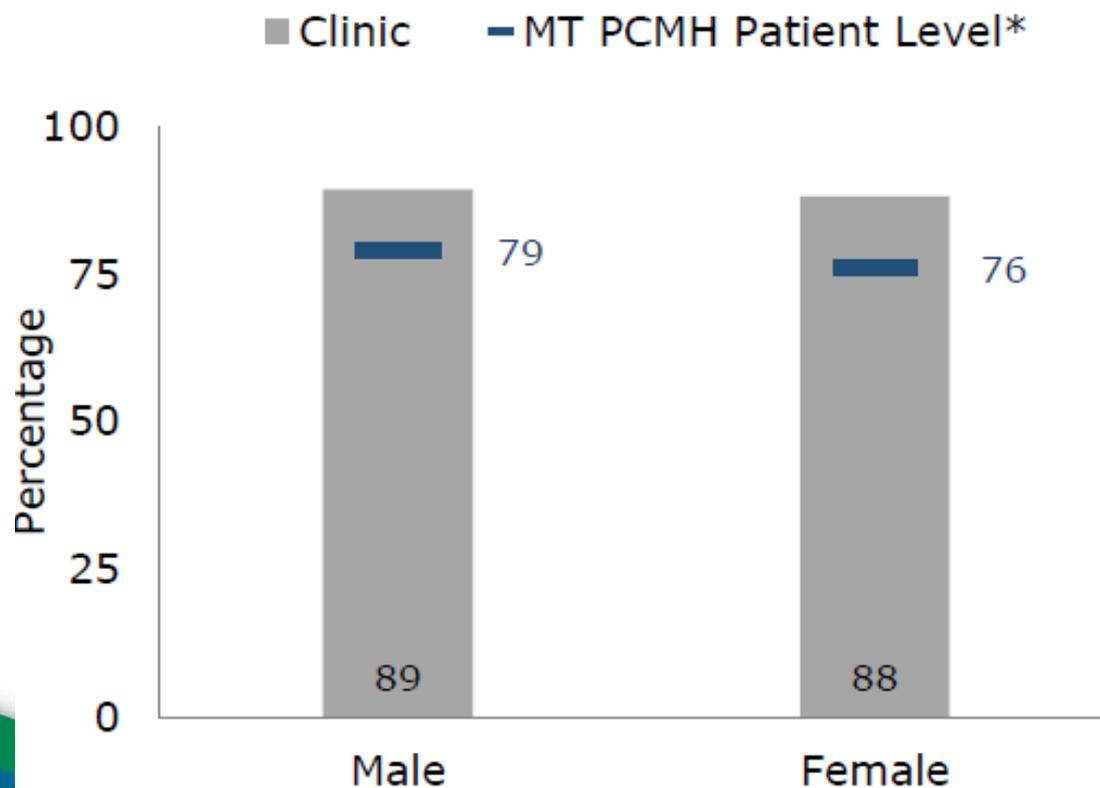
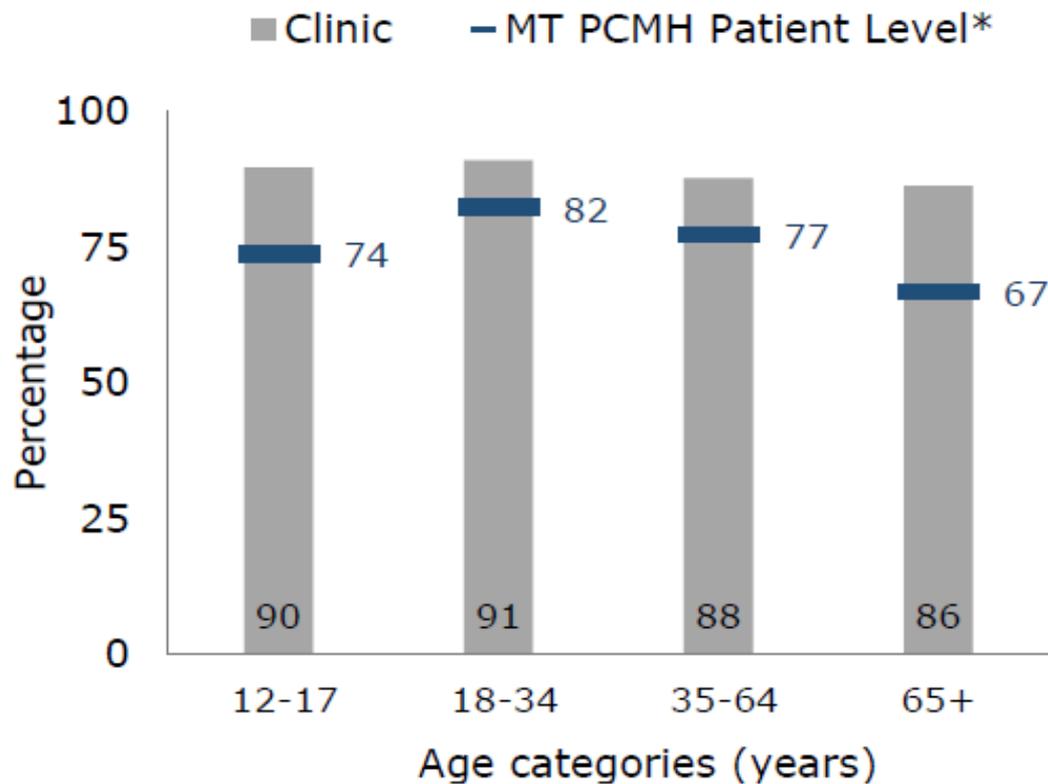


Figure 13. Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen, **by age.**



HTS/DPHHS Technical Assistance

9/19/2016

Patty Kosednar, HTS/Mountain Pacific

Funding Sponsor!

- For the second year in a row, DPHHS is showing their commitment to providing “boots on the ground” quality improvement assistance to healthcare facilities!



DPHHS Technical Assistance (TA) Available

- MT PCMH data extraction, validation and submission assistance
- Electronic clinical quality improvement (eCQI)

MT PCMH Data TA

- Provide education on 2016 data submission guidelines
- Assist with/verify set up of needed EHR data reports for measures
- Assist with data validation
- Establish baseline data for measures
- Review/assist with correct implementation of workflows needed for measures
- Identify quality improvement opportunities
- Assist with 2016 MT PCMH data submission

What is electronic clinical quality improvement (eCQI)

- optimizing health information technology (HIT) and standardized electronic data to achieve measureable improvement in quality of care
- Incorporating the data and functionality of your EHR into your quality improvement projects.
- Health IT enabled Clinical QI (healthit.gov)
<https://ecqi.healthit.gov/content/introduction-electronic-clinical-quality-improvement>

eCQI Technical Assistance

- eCQI project TA may include:
 - Project management, scheduling and documentation assistance
 - Help identifying ROI for QI projects
 - eCQI training and tools and guidance throughout project
 - Quality reporting alignment ideas
 - eCQM and EHR standard reporting knowledge
 - EHR liaison assistance
 - Documentation/tracking/reporting of progress

Streamlined Approach for QI

- Focuses on achieving value added changes quickly and efficiently
- Incorporates Agile (scrum) iterative delivery model
- Aligns quality reporting/improvement initiatives for best ROI for clinic
- Incorporates PDSA (plan, do, study, act) cycle of improvement
- Applies “lite” Project Management needed for success

Quality Improvement Approach

1. Align quality reporting/improvement requirements/initiatives for clinic
2. Choose improvement that provides ROI for clinic
3. First step of improvement is to review workflows:
 - Electronic
 - Data
 - Physical

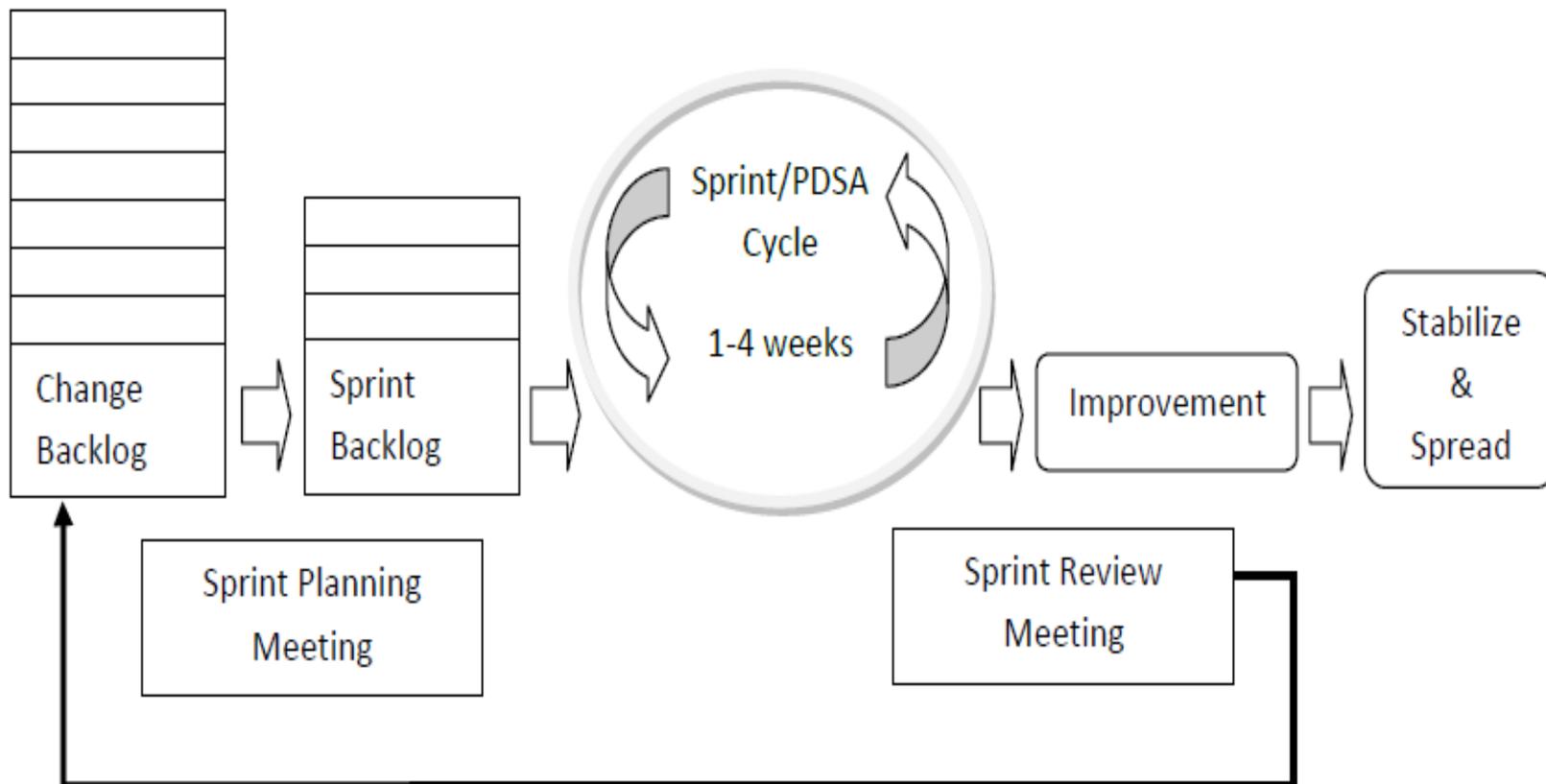
Example of Quality Reporting Requirements for a Clinic

Measure Summary	CMS #	NQF #	PQRS #	NQCA						
				EP MU	PQRS	CSI	PCMH	PCMH	BCBS	eCQI
Clinical Depression screening	2	418	134		x	x			x	
Cholesterol LDL	61	n/a	316					x		
Current Meds	68	419	130					x		
Body Mass Index Screening	69	421	128		x					
Diabetes A1c	122	59	1			x	x		x	x
DM Foot Exams	123	56	119						x	x
Breast cancer	125		112	x	x					
Pneumonia Status	127	43	111	x	x					
Colorectal Screening	130	34	113	x	x					
DM Eye Exams	131	55	117						x	x
DM Urine Protein Screening	134	62	119						x	x
Tobacco Use	138	28	226	x	x	x			x	
Influenza	147	41	110	x	x					
DM LDL Mgmt	163	64	2						x	x
Controlling High BP	165	18	236			x	x		x	
Screening for Osteoporosis	n/a	46	39	x	x					
Urinary Incontinence assessment	n/a	n/a	48	x	x					
Unhealthy Alcohol Use	n/a	2152	431	x	x					

Important Note!

Your quality performance
will be based on the
information in your
EHR!!!!!!

Streamlined eCQI Process Model



eCQI Stats

- Currently recruited 10 clinics, active eCQI projects with 6
- Have completed 3 sprints (PDSA cycles) and have 3 sprints in progress
- Completed sprints have:
 - trained 32 medical staff members on accurate BP
 - positively affected 172 DM patients
 - positively affected 260 HTN patients (not including improved BP measures)
 - improved performance on:
 - Accurate BP readings
 - DM recommended procedures (foot, eye, A1c, LDL, microalbumin)
 - HTN Patient Education
 - HTN Patient follow up visits
 - Are helping to create an eCQI culture for organizations

eCQI Recruited Clinics

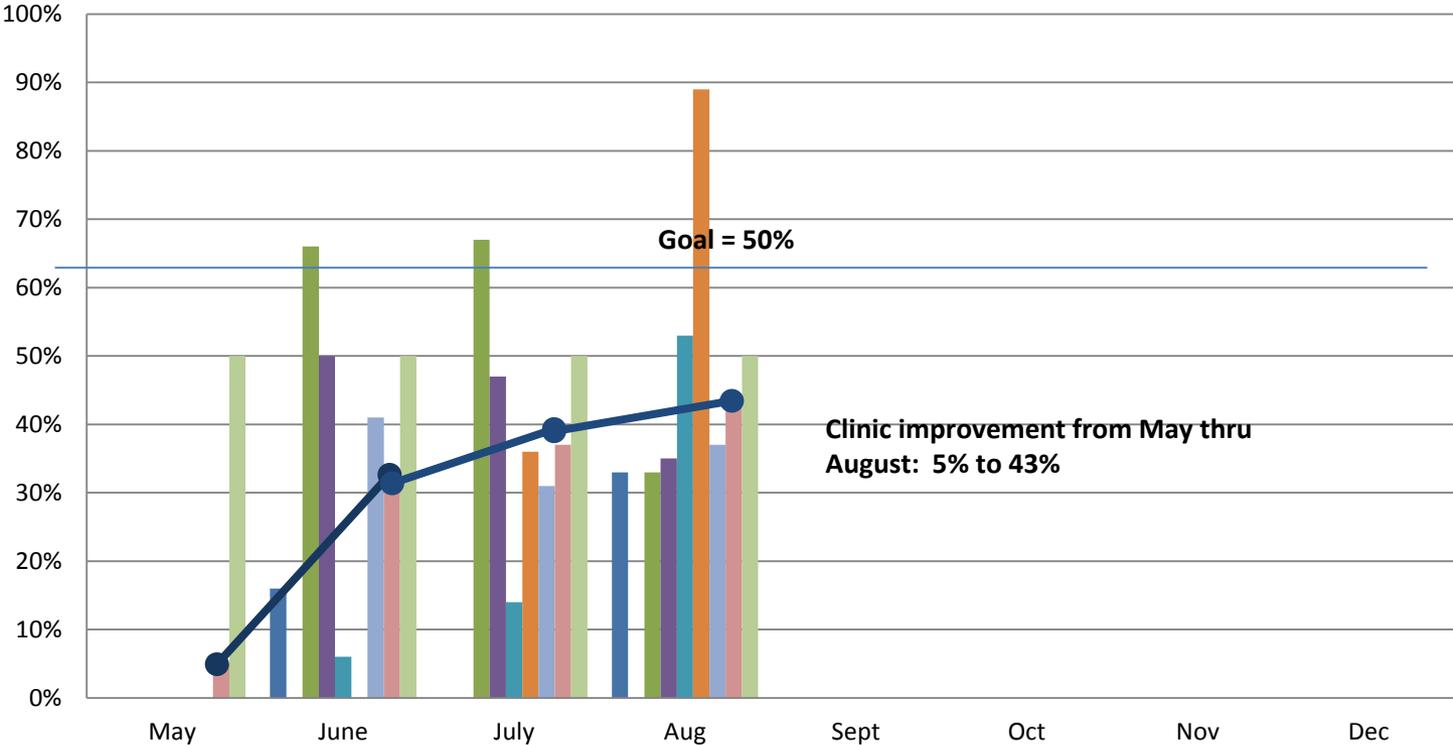
- KRMC – Woodland Clinic (1 clinic)
- KRMC – Big Fork Clinic (1 clinic)
- Northern Montana Healthcare (3 clinics)
- Great Falls Clinics (3 clinics)
- Children’s Clinic of Billings (2 clinics)

eCQI Projects Overview

- KRMC - Woodland Clinic
 - **Project Aim:** Improved outcomes for patients with diabetes.
 - Sprint # 1 - Improved annual DM foot exams performance (CMS #) from 5% to 43% in 2 months
 - Sprint # 2 – Improved
 - DM eye exams from 5% to 20% in 1 month
 - DM Microalbumin exams from 1% 77% in 1 month
 - Sprint # 3 – improve clinical depression screening (just started)

eCQI - Woodland Clinic – cont.

DM Foot Exams 2016 - Woodland



- Doc 1
- Doc 2
- Doc 3
- Doc 4
- Doc 5
- Doc 6
- Doc 7
- Clinic Goal

eCQI Projects Overview

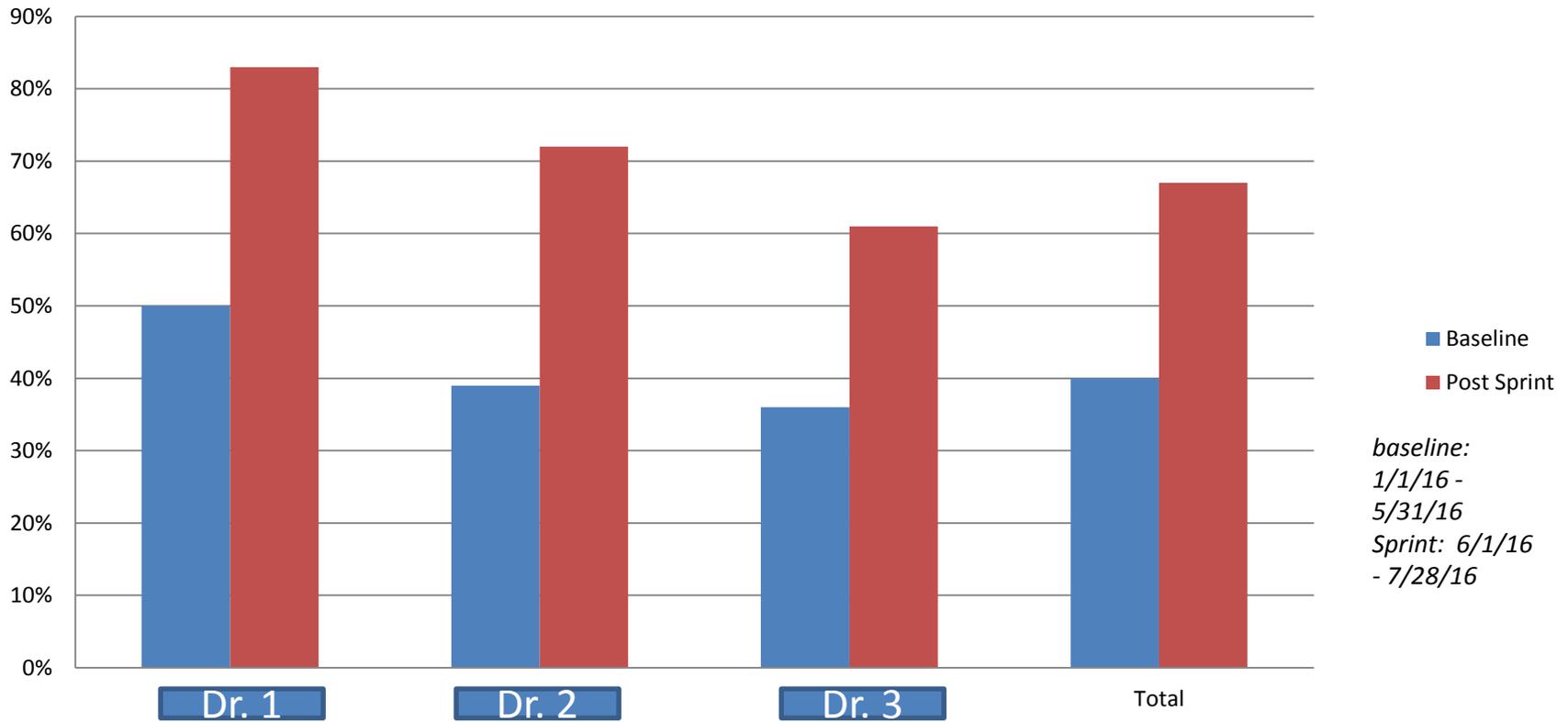
- Northern Montana Healthcare
 - **Project Aim:** Improve CMS 165 – HTN blood pressure control by 20 percentage points by Dec 30, 2016.
 - 1st Sprint: Education and training for accurate BP readings – trained 32 staff and implemented ongoing education/training program
 - 2nd Sprint: Implementation of BP cuff loaner program – in process
 - 3rd Sprint: HTN patients not at goal/new Rx seen within 30 days – Just starting

eCQI Projects Overview

- Great Falls Clinics, 3 clinics/20 providers
 - **Project Aim:** Improve health outcomes for HTN patients
 - 1st sprint: Increase performance on providing patient education to HTN patients
 - 1. Improved HTN patient education from 40% to 67%, in 1 month
 - 2. Of patients receiving education, follow up visits improved from 6% to 16% in 1 month

eCQI Great Falls – NW Clinic

GF-NW Clinic - Patients seen with elevated blood pressure (>140/90), who received patient education - Improved by 27 percentage points in 6 weeks



Other eCQI Projects

- KRMC – Big Fork
 - Just started in mid August. They will focus on improving DM recommended procedures (foot, eye, A1c, LDL, microalbumin)
- The Children’s Clinic of Billings
 - Had first intro call. Will meet with them in mid September to determine eCQI project goals and plan

eCQI Project ideas

- Meet the requirements of MU (or a specific requirement)
- Improve performance on PCMH, PQRS, IQR etc. measures (or a specific measure)
- Improve HCAHPS/CAHPS performance (or a specific measure)
- Improve outcomes for a certain condition (HTN, DM, etc)
- Implement Medicare Care Management Codes
- Implement a new protocol, process or technology
- Implement eCQM reporting out of EHR for MU, PQRS, IQR, etc.

Funded TA Timeline

- Projects can start anytime between now and April 2017.
- Funding cycle ends June 2017.
- There is limited funding, so please contact us right away! First come first served!

Recommended Steps for 2016 PCMH submission

1. Make sure your EHR is currently set up to track all needed MT PCMH measures (changes from last year)
2. Verify data in EHR reports are accurate
3. Make sure your staff is educated on the correct electronic workflows for each measure
4. Periodically monitor data for each measure to verify accuracy and identify quality improvement opportunities

Any Questions?



THANKS 😊

2017 Reporting Guidance

- **Aggregate data still allowed for two more years** – until 2019 – until EMR functionality improves and HIE developments progress further, aggregate data can monitor the goals of the program and quality improvement of PCMHs
- *Please continue to **submit patient-level data** if your clinic is able to do so*
- Reporting required on **4 out of the 5 measures**
- Measures align with CMS standards measure descriptions known as **eCQMs - electronic clinical quality measure standards**

eCQM Standards

1. **Controlling high blood pressure** – last year was CMS 165 V3, is now CMS 165 V4: <https://ecqi.healthit.gov/ep/ecqms-2016-reporting-period/controlling-high-blood-pressure>
2. **Tobacco Use Screening & Cessation** – last year was CMS 138 V3, is now CMS 138 V4: <https://ecqi.healthit.gov/ep/ecqms-2016-reporting-period/controlling-high-blood-pressure>
3. **Diabetes Hemoglobin A1c Poor Control** – last year was CMS 122 V3, is now CMS 122 V4: <https://ecqi.healthit.gov/ep/ecqms-2016-reporting-period/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/ep/ecqms-2016-reporting-period/preventive-care-and-screening-screening-clinical-depression-and>

Immunizations Measure

- Previously aligned with CDC, now **CMS 117v4/NQF 0038**
 - Measures **2-year-olds instead of 3-year-olds**
 - Numerator additionally includes children in the denominator who had a *seropositive test result or had an allergic reaction* to the vaccine by their second birthday
 - 1 Hepatitis A, 2 or 3 Rotavirus, and 2 Flu vaccines were added
 - Specific guidance on patient exceptions from each antigen was added
 - “Note” on directions to document cases of “MC” or “R” separately was removed (None of these cases have been reported separately so far.)

Flow Charts for Patient Populations

- Links to the following charts will be included in the guidance with each measure to show how to pull the population for the numerator and denominator.
 - [Controlling High Blood Pressure](#)
 - [Tobacco Use: Screening and Cessation Intervention](#)
 - [Diabetes: Hemoglobin A1c Poor Control](#)
 - [Childhood Immunization Status](#)
 - [Screening for Clinical Depression and Follow-up Plan](#)

Tobacco/Depression Confusion

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

Questions

For PCMH program support:

Amanda Roccabruna Eby, Project Administrator
Office of the Montana State Auditor
Commissioner of Securities and Insurance (CSI)
(406) 444-4328

For quality improvement related to the measures support:

Kathy Myers, Bureau Chief
Chronic Disease Prevention and Health Promotion
Montana Department of Public Health and Human Services
(406) 444-3385

For health information technology support:

Patty Kosednar, PMP, CPEHR
Consultant
Health Technology Services/Mountain Pacific
www.gotohts.org
(406) 461-4410