RELEVANT 2021 QIP QUALITY MEASURE AND REPORT SET

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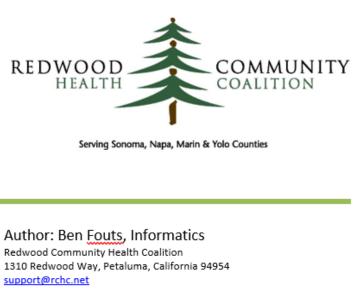
AGENDA

1. General orientation to the QMs and reports

2. Validation

3. Linking to the Partnership denominator

4. Common exclusions

5. Using Value Sets

6. Comments on individual QMs and reports

INSTRUCTION MANUAL

- Will be posted on the RCHC website, along with these slides and this webinar recording

- An official announcement will be sent from RCHC with the location

QIP 2021 Quality Measure and Report Notes and Set-up Instructions (Version 1)

REDWOOD COMMUNITY HEALTH COALITION

Serving Sonoma, Napa, Marin & Yolo Counties

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QIP QM AND REPORT SET

- 12 Quality Measures (QMs) - display graphs over time
- 2 reports – display lists of patients that are candidates for two Unit of Service measures

STANDARD QUALITY MEASURES

- Breast Cancer Screening (QIP 2021)

- Cervical Cancer Screening (QIP 2021)

- Colorectal Cancer Screening (QIP 2021)

- Childhood Immunization Status (QIP 2021)

- Immunizations for Adolescents (QIP 2021)

- Diabetes: HbA1c Good Control (≤9%) (QIP 2021)

- Controlling High Blood Pressure (QIP 2021)

- Counseling for Nutrition for Children/Adolescents (QIP 2021)

- Counseling for Physical Activity for Children/Adolescents (QIP 2021)

- Well-Child Visits in the First 15 Months of Life (QIP 2021)

- Child and Adolescent Well-Care Visits (QIP 2021)

- Asthma Medication Ratio (QIP 2021)

REPORTS

- Advanced Care Planning (QIP 2021)

- Alcohol Misuse Screening and Counseling (QIP 2021)

- Not displayed as Quality Measures because there is no denominator.

- Health Centers are paid per patient (quantity) not paid in relation to a numerator percentage goal (quality)

- Both measures have a minimum threshold. See the QIP Instruction Manual

QM DESIGN

Design aspects from the 2021 QIP instruction document "Primary Care Provider Quality Improvement Program (PCP QIP) Specifications, Published: January 8, 2021."

The instruction manual is not as detailed as it was in other years

ALL PRACTICE TYPES

Primary Care Provider
Quality Improvement Program (PCP QIP)
Specifications
Published: January 8, 2021

2021
MEASUREMENT YEAR

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

QM DESIGN

- Also used the QM Highlight documents. These are 2-5 page resources about each measure

- They can be accessed here: http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Measure-Highlights.aspx

- 2021 HEDIS instructions also occasionally referenced in the QM design

2021 Quality Measure Highlight
Breast Cancer Screening

MEASURE DESCRIPTION
The percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer.

Denominator: Women 52 - 74 years of age as of December 31 of the measurement year.

Numerator: Women with one or more mammograms any time two years prior to the measurement year (On or between October 1, 2019 and December 31, 2021)

Measure Type: Administrative (claims)

This measure assesses the use of imaging to detect early breast cancer in women. All types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) qualify for numerator compliance.

Do not count MRIs, ultrasounds or biopsies towards the numerator; although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count toward the numerator.

Intent / Importance: Mammograms are the best method to detect breast cancer early on, before it is big enough to feel or cause symptoms and is easier to treat.[1] Detecting breast cancer early via mammography can provide women with a greater range of treatment options, such as less aggressive surgery (e.g., lumpectomy vs. mastectomy), less toxic chemotherapy or the option to forego chemotherapy. Early detection of breast cancer through mammography can also reduce the risk of dying from breast cancer by 20 percent.[2] The U.S. Preventive Services Task Force (USPSTF) and the American College of Physicians recommend that women ages 50 - 74 should have biennial (every two years) screening.

Coding
Mammography CPT: 77061; 77062; 77063; 77065; 77066; 77067

Diagnosis codes: Z90.11, Z90.12, Z90.13

QM DESIGN

- All Quality Measures and Reports rely on the Relevant Analytics Database (AKA, the Production Database) and contain the same SQL code for all health center instances of Relevant.

- They borrow from the SQL code used in the 2019 QMs, but with appropriate modifications

QM DESIGN

- TEMPORARY TABLES used for each measure

- Generally, it starts with a universe Temporary Table that defines the initial denominator

- Following is a numerator Temporary Table (can have different names but the Note says it is for the numerator)

- Then there is an exclusion Temporary Table (can have different names but the Note says it is for the exclusion)

- Lastly, there is a results query that brings everything together

QM DESIGN

- The results query contains the same standard five fields used by other QMs. Therefore, the standard filters for location, provider, etc. are featured

- Displays results in graph forms just like the other QMs

HEALTH CENTER RECOMMENDATIONS

- Add a Full Points threshold to the QM graph

- Add the QMs to any groups you have established in Relevant

UDS VS QIP QMS

- There are differences between the definitions of the QIP and UDS measures. This includes measures with similar names and similar descriptions.

- Therefore, it is very likely that you will <u>not</u> see the same exact numerators and denominators for pairs of QIP-UDS Quality Measures

- For example, age ranges and exclusions often have slight differences

- Nonetheless, most measures should be in the "ball-park" range

VALIDATION OF QMS AND REPORTS

- Health centers should thoroughly validate the QIP Quality Measure and Report set before activating and using them for clinical or reporting purposes.

- By default, they will be initially disabled in your Toolbox. It is assumed that the Programmer or Data Analyst at your health center has the administrative rights to see an unpublished QM or report.

- Finish validation before displaying the graphs for your providers and staff, and before reporting any results to PHP.

VALIDATION OF REPORTS

- Ben Fouts (bfouts@rchc.net) will be the contact person for questions or data findings. The report should display data as you see it in your EHR and analyze it appropriately.

- If you have a finding, it is best to send (securely) record identifiers, dates, values, etc. so Ben can trace specific data on his end

- It is less helpful to generally say "the numbers look low to me" or ask "why are the QIP and UDS numbers different?"

DATA VALIDATION

- The RCHC QIP Instruction Manual describes the data-cleaning reports from the RCHC Validation Report Set for each measure.

- Separate validation reports display missing or erroneous records so that can be reviewed. This process contributes to increasing the accuracy and completeness of the measure.

- Refer to the separate manual "Instructions for Using the Relevant Validation Report Set" available from RCHC.

THE GOAL IS TO EVENTUALLY SWAP OUT THE DEFAULT DENOMINATOR FOR THE PHP DENOMINATOR

- The initial version of the QMs is called the "default" version

- Because the health center EHR typically cannot be used to precisely identify the true Partnership denominator, the default denominator is applied to all patients in the EHR

- For this definition, patients must have had at least one medical visit in the past year and meet the rest of the measure denominator criteria. This is different than the Partnership denominator definition which focuses on patients with Partnership insurance assigned to the health center and who may or may not have had an actual visit in the past year

THE GOAL IS TO EVENTUALLY SWAP OUT THE DEFAULT DENOMINATOR FOR THE PHP DENOMINATOR

- Since health centers have different data workflows and data personnel, they are free to decide their own suitable method to link the QMs and reports to Partnership patients

- See the Data Workgroup webinar slides and presentation from last month

- When your health center establishes a routine to download and display PHP measure denominator patients in Relevant, these files can be used in the "universe" Temporary Table instead of the criteria there. The PHP denominator is the **true** universe for the QIP measure

- Leave the "universe" Temporary Table in the SQL because it is used in the results table and possible other parts of the SQL code

DISPLAY THE QUALITY MEASURE RESULTS OVER TIME

- If using your Partnership denominators, your QM graph will begin on the first month of your downloaded data

- Remember that the QM denominator for each month is based on the denominator downloaded for that month. Thus, the SQL code should have a routine for identifying the correct Partnership denominator month-by-month so that the QM graph can be displayed over time

END OF LIFE EXCLUSIONS

Some reports share end of life exclusion criteria. These reports are:

- Breast Cancer Screening (QIP 2021)

- Colorectal Cancer Screening (QIP 2021)

- Diabetes: HbA1c Good Control (≤9%) (QIP 2021)

- Controlling High Blood Pressure (QIP 2021)

END OF LIFE EXCLUSIONS

End-of-life conditions have any of the following characteristics:

- Patients in hospice or palliative care overlapping the measurement period

- Patients over 65 years of age (relative to the end of the measurement period) who stayed in long-term care for at least 90 days during the measurement period

- Patients over 65 years of age (relative to the end of the measurement period) who had a diagnosis of frailty (defined by the value set) along with at least one of the following:

  - ✓ Diagnosis of advanced illness (defined by the value set) in the two years prior to the end of the measurement period

  - ✓ Dementia medications in the two years prior to the end of the measurement period

OTHER SIMILAR EXCLUSIONS

Hospice Care:

- Cervical Cancer Screening (QIP 2021) – along with palliative care

- Childhood Immunization Status (QIP 2021)

- Immunizations for Adolescents (QIP 2021)

MAKE SURE YOUR IMPORTERS ARE SET-UP

- hospice_care_interventions

- palliative_care_cases

- long_term_care_stays

- frailty_cases

- advanced_illness_cases

- dementia_medications

VALUE SETS

- It is recommended that Importers (or associated Transformers) directly utilize the designated Value Set for diagnosis, procedure, lab, and immunization codes.

- The Appendix in RCHC instruction manual contains detail about Value Sets

Quality Measure or Report Name	Importer	Value Set Name (default eCQM)	OID (eCQM) or Unique Name	Value Set Type
Breast Cancer Screening (QIP 2021)	mammograms	No applicable Value Set (see Note #1)		
	mastectomies	History of bilateral mastectomy	2.16.840.1.113883.3.464.1003.198.12.1068	Diagnosis
		Status Post Left Mastectomy	2.16.840.1.113883.3.464.1003.198.12.1069	Diagnosis
		Status Post Right Mastectomy	2.16.840.1.113883.3.464.1003.198.12.1070	Diagnosis
		Unilateral Mastectomy, Unspecified Laterality	2.16.840.1.113883.3.464.1003.198.12.1071	Diagnosis
Cervical Cancer Screening (QIP 2021)	pap_tests	Pap Test	2.16.840.1.113883.3.464.1003.108.12.1017	Labs
	hpv_tests	HPV Test	2.16.840.1.113883.3.464.1003.110.12.1059	Labs
	hysterectomies	Hysterectomy with No Residual Cervix	2.16.840.1.113883.3.464.1003.198.12.1014	Diagnosis
	congenital_absence_cervix_cases	QIP: Absence of Cervix	No eCQM. See Note #2	Diagnosis

VALUE SETS

- You can use the eCQM Value Sets when there is a single Importer for the UDS and QIP reports

- Some Value Sets are unique to the QIP

BRIEF NOTES ON INDIVIDUAL MEASURES

BREAST CANCER SCREENING

- The Mastectomy Importer must be designed properly or there will be a risk of excluding too many patients from the denominator.

- The measure excludes patients who have had one complete bilateral mastectomy or two complete unilateral mastectomies

- The SQL code in the QM looks at the Mastectomy Importer for:

  - A bilateral mastectomy, where field name "bilateral" = TRUE

  - OR two unilateral mastectomies, where field name "bilateral" = FALSE

- Therefore, the Importer should display one record for one unilateral mastectomy for one side with one surgery date

CHRONIC DISEASE DIAGNOSIS CODES

- The default denominators for the measures focusing on patients with diabetes (HbA1c Good Control), hypertension (Controlling High Blood Pressure) and asthma (Asthma Medication Ratio) rely on the use of Value Sets of diagnosis codes

- At most health centers, the Importers that identify these patients (essential_hypertension_cases, diabetes_cases, and asthma_cases) use the Problem List as the source of truth for chronic disease diagnosis

- A report that is part of the RCHC Validation Report set can help to identify patients that can be reviewed for diagnosis accuracy

CHRONIC DISEASE DIAGNOSIS CODES

- Even though it is relatively rare that these chronic diseases are somehow "cured" there are cases where the diagnosis code is resolved or otherwise removed from the Problem List.

- Therefore, the Importer or Transformer SQL code should have the ability to display an end_date for the diagnosis if no longer active.

- The default version of the QM uses the OVERLAP method to determine if, historically, the patient had a diagnosis at the time of the numerator measurement

HYPERTENSION: CONTROLLING BLOOD PRESSURE

- All blood pressures accepted. This is different than the UDS report.

- This tends to make the QIP numerator percentage higher than the UDS, especially for recent (i.e., 2020-2021) dates when many patients were having virtual visits

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE --AND -- CHILD AND ADOLESCENT WELL-CARE VISITS

- The Quality Measure SQL assumes that all well-child visits identified by the Importer well_child_interventions meet all of the criteria defined by Partnership HealthPlan and counts them accordingly.

- "Well child visits" are defined by the same codes for both the infant and the child/adolescent reports

- Therefore, the Importer well_child_interventions can be used for both

- Note that the Value Set contains both CPT and ICD codes

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

- Note that the <u>old</u> version of the QM "Well-Child Visits in the First 15 Months of Life" pulled CPT codes directly from claims.

- This kind of process should be done on the Transformer/Importer level, not the report/QM level.

- Therefore, you may need to modify the Importer well_child_interventions to identify all Well Child visits that are eligible for the measure

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE --AND -- CHILD AND ADOLESCENT WELL-CARE VISITS

- Furthermore, the QM Highlights for these measures state that the "well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child."

- This provision must be considered on the level of the Importer well_child_interventions.

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

- For this measure only, well-care visits must be at least 14 days apart in order to be counted by the report. Therefore, it might be the case that the number of visits in the EHR differs from the count on the report unless the 14 day rule is manually applied.

- This will reduce the numerator percentage for the measure and make it harder to achieve full points

- A study I did showed that for all RCHC health centers, the overall reduction is around 25%

- Half of patients had one or two visits within 14 days of another visit

- Of patients who were knocked out of the numerator, three-quarters had one or two visits within 14 days of another visit

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE --AND -- CHILD AND ADOLESCENT WELL-CARE VISITS

- Like the other QMs in this set, the default version of these reports count patients who had at least one medical visit in the measurement period

- This will tend to bias the measure to a higher numerator percentage than if the actual Partnership-supplied denominator is used

- For the default version, this is the way that "current patients" is defined. Your health center can define it differently using a different span of time (e.g., one visit in the past 18 months, etc). But just keep in-mind that the further back you go, the less likely the patient is still "current"

- The Partnership-supplied list consists of "current" patients because they currently have Partnership insurance and are currently assigned to your health center. Without that list, it is hard to say who is currently expected to be seen (i.e., we can only say that they are current because they have been seen recently)

CHILD AND ADOLESCENT WELL-CARE VISITS

- This is a new measure. The patient age range is between 3 and 17 years.

- It is a combination of the 2020 Monitoring Measures "Well-Child Visits (3 – 6 Years Old)" and "Adolescent Well-Care Visits (12 – 21 Years Old)."

- A minimum of one well-child visit is needed for the numerator

- Therefore, the "14-day" rule is not needed

CHILDHOOD IMMUNIZATION STATUS --AND-- IMMUNIZATIONS FOR ADOLESCENTS

- See the RCHC instruction manual, the QIP instructions and/or the QM highlights for the number of vaccines necessary to be counted within particular periods of time

- For example (childhood), one chicken pox (VZV) on or between the first and second birthdays.

- For example (adolescent), one meningococcal conjugate vaccine (MCV) on or between the eleventh and thirteenth birthdays

- If a vaccine is given outside of that time frame, it is not counted by the report. Therefore, the count in the EHR may look different than the count on the report unless the specific time frames is considered.

- Assumptions: the time frames are based on clinical recommendations, so there should not be a huge difference

CHILDHOOD IMMUNIZATION STATUS --AND-- IMMUNIZATIONS FOR ADOLESCENTS

- There are several vaccine Importers. The Importers related to the childhood immunizations can use the eCQM Value Sets, but the ones for the adolescent immunizations must rely on the QIP Value Sets

- Because immunizations are being counted, the Importers should display unique records like this: one patient with one vaccine administered on one date.

- If duplicate records appear or a single dose appears with different dates, then the report will over-count the number of vaccines.

IMMUNIZATIONS FOR ADOLESCENTS

There are two options for the human papillomavirus vaccine portion of the numerator. The QM evaluates both between the patient's ninth and thirteenth birthdays:

- Two vaccinations at least 146 days apart

- Three or more total vaccinations

If the patient had exactly two vaccines but they were not at least 146 days apart, the measurement_value in the detailed results will read "HPV doses too close (shots 2/2)" and the patient will not be in the numerator

COUNSELING FOR NUTRITION COUNSELING FOR CHILDREN/ADOLESCENTS --AND-- COUNSELING FOR PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS

- New measures

- They are not exactly the same as the UDS measure for child weight because neither of these consider if the child had a BMI percentile

- However, the Importers for the two types on counseling are the same and use the same Value Sets

ASTHMA MEDICATION RATIO

- The QM Highlight says that the measure is "based on administrative data; there is no manual upload to eReports."

- The HEDIS denominator definition is very complex and heavily weighs on billing data, particularly visits with a principal diagnosis of asthma. It also considers Emergency Department visits and acute inpatient stays.

- The health center EHR displays the prescriptions and refills given to the patient, but it is usually unknown what is picked up by the patient

- Therefore, Partnership has access to a lot more information needed to define the struct HEDIS definition than an EHR does

ASTHMA MEDICATION RATIO

- Therefore, the default denominator has been simplified to focuses on patients with:

  - A diagnosis of persistent asthma

  - At least one medical visit in the measurement period

  - At least one asthma medication dispensing event in the measurement period

- Note: because the measure denominator requires an asthma medication dispensing event, if your asthma medications Importer is not established, the default QM will display zero patients

IMPORTER ASTHMA_MEDICATIONS

- Typically based on the Transformer "relevant_asthma_medications"

- The SQL code in this Transformer identifies all asthma medications (by name), determines the type (oral, injection or inhaler), and the class (rescue or controller).

- The Transformer also makes calculations for the units dispensed and the days supply, which are needed for additional calculations in the Quality Measure, depending on the medication type

CALCULATING "UNITS"

- The units for inhalers and injections are pretty straightforward (i.e., one inhaler or one injection is one unit).

- However, the units for oral medications requires a calculation, which is made in the Transformer

CALCULATION FOR ORAL MEDICATION "UNITS"

- One unit is a prescription lasting 30 days (or, in other words, divide the days supply by 30 and round-down).

- For example, if an oral medication has a package size lasting 30 days, it is one unit. A package size of 100 days is 3 units (100 divided by 30 and rounded down).

- Therefore, the "days_supply" field for oral medications on the Importer asthma_medications is very important

THE "DAYS_SUPPLY" FIELD

- Or, in other words, the "days_supply" field on the Transformer relevant_asthma_medications

- A number appears in this field for oral medications only

- Examine the raw data from your EHR and how the Transformer is interpreting it

THE "DAYS_SUPPLY" FIELD, FOR EXAMPLE:

- Most common entries

Raw text	days_supply
21 days	30
30 day(s)	30
60 days	60
100 days	100

- But what about…

Raw text	days_supply
2 months	?
1 wk	?
4 weeks	?
100	?

UNIT OF SERVICE REPORT: ADVANCED CARE PLANNING

- Uses the Importer "advance_care_plannings"

- Right now, this Importer only has a date that the advance care planning was done

- Hopefully, future version of the report can provide additional information, like the type of advance care planning (i.e., a documented Advance Directive or POLST), if education was performed, etc.

- For now, you should still verify the advance care planning in the EHR before completing an attestation

UNIT OF SERVICE REPORT: ALCOHOL MISUSE SCREENING AND COUNSELING

- Partnership covers up to two screenings for an individual every six months

- Two CPT codes: G0442 (Alcohol screening) and G0443 (Alcohol counseling)

- Report displays all adult patients and the dates of up to two alcohol screening and counseling activities in the Measurement Period

- The user decides the measurement period in the parameters

UNIT OF SERVICE REPORT: ALCOHOL MISUSE SCREENING AND COUNSELING

- When the report is joined to a list of the current Partnership patients, it can calculate the screening rate (the threshold is 5% in order to get an incentive payment)

- There may be an alcohol screening and counseling Importer developed this year in order to display additional information about screening activities and results. If this information comes from Structured Data, the report will be upgraded so health centers can look for Partnership patients who had screening/counseling activities that were not billed.

QUESTIONS?