**Issues for the RCHC Data Standards and Integrity Committee**

May 6, 2019 Meeting

Version 1, By Ben Fouts MPH, RCHC Data Analyst

1. **Meaningful Use Reports: A Priority for the Near-Future RCHC Relevant Report Set?**

Possible Report Set: Meaningful Use Measures

Issue: Even though health centers might no longer be reporting measures for the different stages of Meaningful Use certification, there may still be interest in seeing the data in Relevant for certain measures.

Questions for the Group: Are any health centers reporting Meaningful Use measures in 2019 that require data-gathering from patient records in their EHR[[1]](#footnote-1) ? Are any health centers still tracking Meaningful Use measures for their own internal purposes? For example, in eCW, there is the Meaningful Use, Adoption, Quality (MAQ) Dashboard. Are there any eCW health centers still using it, or are other health centers (like those with NextGen) using their own system?

Description: Here are some examples of patient-record measures from Meaningful Use.

* Generate and transmit permissible prescriptions electronically (percentage of permissible prescriptions that are transmitted electronically)
* Completed patient demographic data (percentage of unique patients with all demographics recorded as structured data, including preferred language, gender, race, ethnicity, and date of birth)
* Maintain an up-to-date problem list of current and active diagnoses (percentage of unique patients with at least one problem entry, or an indication that no problems are known for the patient, recorded as structured data)
* Maintain the patient’s active medication list (percentage of unique patients with at least one medication entry, or an indication that the patient is not currently prescribed any medication, recorded as structured data)
* Maintain the patient’s active medication allergy list (percentage of unique patients with at least one medication allergy entry, or an indication that the patient has no known medication allergies, recorded as structured data)
* Record and chart changes in vital signs (percentage of unique patients age 2 years and over with height, weight and blood pressure recorded as structured data)
* Record smoking status for patients 13 years old or older (percentage of unique patients age 13 years and over with smoking status recorded as structured data)
* Provide clinical summaries for patient for each office visit (percentage of office visits with a clinical summary provided within three business days)
* Document clinical lab test results as structured data (percentage of clinical lab test results ordered whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data)
* Medication reconciliation (percentage of transitions of care in which medication reconciliation is performed)

1. **Definition of Additional Relevant QIP Measures**

Possible Report Set: Partnership QIP

Issue: Two 2019 QIP Measures do not have standards for data entry. We should start a discussion of the ‘best’ place to store the data, beginning with where health centers might be storing them now.

Description: The two measures are described below. Refer to the 2019 QIP instructions for more detail. Note that the 2018 SBIRT measure is no longer part of the QIP.

1. **Advanced Care Planning** (Measure 16). A health center has an opportunity for payment based on the number of advanced care planning “discussions” and the number of approved advanced directives or POLST forms submitted. The number reported cannot include any advanced care planning that has already been reimbursed through the appropriate CPT codes.

* Data will be submitted through eReports. Completion of an attestation form template is necessary.
* Do we want to:

1. Simply be able to count the number of discussions and forms approved so we can keep track of progress towards a goal? Like other Relevant reports, a user can go in and see the list of patients in order to further review the record and complete the template.
2. Have places for providers to potentially enter all the required documentation, like:
   * Conversation about patient goals, general preferences around end of life
   * Conversation with family
   * Status of the Advance Directive or POLST (discussed, given to patient, completed, etc.)
   * Summary of patient wishes
   * Plan for next conversation.
3. **Initial Health Assessment Improvement Plan** (Measure 22). The health center must schedule an Initial Health Assessment (IHA) for patients within 120 days of becoming a PHC member.

* Data will be submitted through fax or e-mail. Completion of a template is necessary.
* Do we want to:

1. Simply be able to count the number of IHAs so we can keep track of progress towards a goal? Or, it could be set-up like a Quality Measure (i.e., the number of IHAs over the number of new patients). Like other Relevant reports, a user can go in and see the list of patients in order to further review the record and complete the template.
2. Have places for providers to potentially enter all the required documentation, like identifying specific locations in the health record for:
   * Physical and mental history
   * Identification of high-risk behaviors
   * Assessment of need for preventative screenings or services, and health education
   * Diagnosis and plan for treatment of any diseases
   * A completed SHA (Staying Healthy Assessment)

Note that in the two measures explained above, identifying specific locations for the detailed data can also help you on internal performance improvement. For example, you could track the number of new patients who do not get an assessment of high-risk behaviors, by provider or team, if that is part of your clinical guidelines. This could be incorporated into Care Gaps and/or a Report.

1. **Definition of Relevant Income Level**

Report: Relevant UDS Summary (Table 4 tab)

Issue: What is the most realistic way to define the income level of a patient so it both, 1) fits the UDS definition, and 2) maximizes the number of patients with reported income. Health centers with large numbers of patients with unknown income are often questioned about it by their UDS Editor.

Description: The 2018 UDS Manual states the following guidelines for the collection of patient income (page 38): “Collect income data on all patients once during the year... Report “unknown” income on Line 5 for patients whose information was not collected within the calendar year.”

However, a strict interpretation of this guideline would exclude a very large number of patients from the poverty table (Table 4) and is not consistent with the way health centers typically assign and apply the sliding fee schedule. At many health centers, a patient is assigned a sliding fee scale that expires 12 months after income is documented. Patients are not normally expected to bring in all of their income documentation for every visit in order to maintain qualification for the scale.

A large group of patients would be classified as “Unknown” according to a strict interpretation of the guideline. These include patients who are seen within the calendar year and ONLY within 12 months of their sliding fee scale assignment. If they do not return after the 12-month mark, there is no opportunity to document their income in the calendar year.

Example: A patient has income documented on December 28, 2018 and returns to the health center ten times in 2019, all before December 27, 2019. Since the patient’s sliding fee scale did not expire before any visit, the patient was not asked again about income. Would this patient be classified as “Unknown”?

Additional Information: The UDS manual (page 38) also reads “Income, as defined by board policy consistent with the Health Center Program Compliance Manual, is used.” The Health Center Program Compliance Manual says “The health center has operating procedures for assessing/re-assessing all patients for income and family size consistent with board-approved sliding fee discount program policies” (reference: page 40 of the August 2018 version). Could a health center define the frequency of income documentation and then report income on the UDS consistent with that policy? Could this policy be written in a way that would maximize the number of patients reported on Table 4?

Note: At some of the health centers, poverty level is defined by the Importer “Patient Annual Poverty Levels.” Check how your health center is defining poverty level. Probably not acceptable are cases where the last income is used, regardless of when it was documented or expired.

1. **Updating Measure Set Codes Year-to-Year**

Report: All reports that rely on value set codes

Issue: As the codes used to define the measures change over time, how important is it that we keep an archive of outdated Quality Measures that rely on old codes.

Description: Most of the Quality Measures we track rely on CQM Value Sets that officially define diagnosis codes, procedure codes, lab codes, etc. for each measure. A few months back, the Data Standards and Integrity Committee decided that, instead of manually identifying changes in the Value Sets and updating the SQL code for every report every year, the reports would directly link to a large table of codes through the Object Identifier (OID) number. That way, only the underlying Value Set table (which can be downloaded from the Value Set Authority Center) needs to be replaced. This approach would save a lot of time and reduce errors.

However, either approach has the same problem. How do we handle “old” measures relying on “old” Value Sets in Relevant? For example, in Relevant, there is a Transformer named “relevant\_diabetics” that uses the Value Set code table to identify patients with diabetes. For illustrative purposes, let’s say the ICD codes for diabetes change in some way for the 2020 measure. The 2020 Value Set table would replace the 2019 Value Set table and both the Transformer and the 2020 Diabetes Quality Measure would be based on the new set of codes.

However, because the “relevant\_diabetics” Transformer defines patients with diabetes in a general sense, the 2019 Diabetes Quality Measure (and any other reports using it) would then display patients with the new set of codes and would not be historically accurate.

Additional Information: Will health centers have a need to see historical measures in the future? For example, in 2020, will someone want to still see the 2017 and the 2018 Diabetes Quality Measures in Relevant? The answer to this question will help us decide if we need to somehow keep old Value Sets in Relevant and maintain their linkages to previous Quality Measures.

Note that we should decide if there should be some kind of overlap in the Quality Measures at the beginning of each year. For example, early next year, you will need to see the 2019 Quality Measures for the UDS report while at the same time the 2020 Quality Measures might be available for testing. The alternative is that there is a hard “shut-off” date where the 2019 measures are replaced by 2020 measures (or, at least the Value Sets changed over).

Possible options include:

1. Keep old Quality Measures available in Relevant and maintain their attachment to old Value Sets. The trade-off of having this information available is that it likely will require more background work and organization. Continuing the example above, would we need to create a special Transformer for “relevant\_diabetics\_2019” to keep the 2019 Value Set codes? Would it be confusing to eventually have a number of such transformers?
2. Keep old Quality Measures available in Relevant but update the underlying Value Sets to the most recent code sets on an agreed-upon date. Before that date, the new Quality Measures could not be tested. After that date, the old Quality Measures might display slightly different data. Health centers could then inactivate their old Quality Measures themselves when they switch to the new Quality Measures during the year.
3. Another option?

In either case, RCHC could prepare a summary of the code changes year-to-year for each measure so everybody is clear.

1. This does not include things like attesting that you participate in some kind of health information exchange, etc. [↑](#footnote-ref-1)