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

September 10, 2018 Meeting

Version 1, By Ben Fouts MPH, RCHC Data Analyst

1. **Exclusion Definition for the Coronary Artery Disease Measure**

Report: Coronary Artery Disease (CAD): Lipid Therapy

Issue: The UDS instructions for the CAD measure seem to exclude patients who are successfully being treated for CAD. Should the literal exclusion definition be applied, which would mean changing the BridgeIT report?

Description: During the comparison of the Relevant and BridgeIT results, it was found that the Relevant denominator was smaller and the numerator percentage was lower as compared to BridgeIT. Further investigation found that Relevant was excluding all patients with a low-density lipoprotein (LDL) lab test less than 130 mg/dL. The BridgeIT report was excluding only patients with an LDL lab test less than 130 mg/dL who were **not** using a lipid lowering medication (in other words, who were not already in the numerator).

There is no eCQM for this measure, so we only have the UDS instructions. The Relevant report is following the literal 2018 UDS instructions, which say to exclude “Patients whose last low-density lipoprotein (LDL) lab test during the measurement year was less than 130 mg/dL” (page 92).

The main question is, should we keep the BridgeIT definition of the exclusion?

Pro: The current BridgeIT perspective is that the goal of lipid therapy for patients with CAD is to lower LDL. Over time, patients who are on lipid therapy medications should lower their LDL to under 130 mg/dL. This is the intended consequence. Therefore, why exclude them from the measure once they reach that goal? These are the patients who are the “success story” of the medication and, if they were to stop using the medication, presumably would see their LDL rise again. Health centers can use their BridgeIT CAD report (version 5) to see that there are relatively a lot of patients with CAD using lipid therapy and LDL under 130 mg/dL.

Con: The literal definition says to exclude them. Therefore, only patients with CAD and high LDL (over 130 mg/dL) or no LDL in the past year would be included in the denominator.

1. **Age Calculation**

Report: All reports that use an age range to define the denominator (but does not include childhood vaccination reports)

Issue: Many measures have an age range that, in part, defines the measure denominator. Relative to what date should a patient’s age be calculated?

Description: During the comparison of the Relevant and BridgeIT results, it was found that the denominators were slightly different. Further investigation found that the age calculation was different which particularly effected patients with birthdays in the measurement period that newly included them in the denominator definition. Most BridgeIT reports calculate age relative to the last day of the measurement period.

Additional Information: The UDS instructions state age ranges and birthday ranges. These have been inconsistent year-to-year and, in some cases, the birthday range disagrees with the QIP instructions for measures with the same age range. Therefore, it is difficult to define a true definition.

For example, let’s examine the diabetes measure. Here are the definitions, as quoted from the 2018 instruction manuals:

|  |  |  |
| --- | --- | --- |
| Range | UDS | QIP |
| Age range | Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period | The percentage of members 18-75 years of age who had a diagnosis of diabetes with evidence of HbA1c levels at or below the threshold. |
| Birthday range | Note: Include patients who were born on or after January 1, 1943, and on or before December 31, 1999. | The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1943 and December 31, 2000) with diabetes identified as of December 31, 2018 |

Here are the ages of the patients at the extreme ends of the birthday ranges:

|  |  |  |  |
| --- | --- | --- | --- |
| Birthdate | Relative to beginning of measurement period | Relative to end of measurement period | Comment |
| Age on January 1, 2018 | Age on December 31, 2018 |
| 1/1/1943 | 75 | 75 | This patient was 75 years of age during the entire measurement period |
| 12/31/1999 | 18 | 19 | This patient was 18 years of age at the beginning of the measurement period |
| 12/31/2000 | 17 | 18 | This patient turned 18 years of age during the measurement period |

The age calculation used in BridgeIT (i.e., AgeEndReporting between 18 and 75) includes patients who have their 18th birthday in 2018. The age calculation in Relevant (i.e., YEAR FROM age({{measurement\_period\_start\_date}}, patients.date\_of\_birth) BETWEEN 18 AND 74) does not.

So, the main questions are:

1. Do we want to include patients who turn 18 years of age during the measurement period?
2. Do we calculate age based on a fixed definition (i.e., age at beginning or end of measurement period)?
3. Alternately, do we calculate age based on visit date (i.e., age at first or last visit in the measurement period)?
4. **Definition of** **Primary Care Medical Visit**

Report: All reports

Issue: Affirm that the definition of a primary care medical visit follows the UDS definition for all reports. This standard will be held in the programming of the Relevant and BridgeIT reports.

Description: The 2018 UDS Manual States that a Primary Care Medical Visit has the following characteristics:

* Visit is with a licensed or credentialed medical provider who exercises independent, professional judgment in providing services.
* Must be a face-to-face contact
* Services must be documented in the chart
* The visit must take place in health center sites or other locations approved within the health center’s scope of project.

How do we know that a patient was “seen” by a provider and therefore should be counted as a visit? Most visits are checked out (CHK in eCW), with the visit notes closed (locked in eCW) and a claim attached. However, this is not always the case. There is a bit of a grey area, especially since some visits with primary care providers do not (yet?) have all of these characteristics.

For example, in BridgeIT, a visit is also defined as having an attached Assessment. That is, if a patient was assessed by a primary care medical provider, the patient was “seen.” This is true regardless of claim status or the visit type (excluding telephone visits, virtual visits, etc.)

Some validation should be done at individual health centers to make sure that no primary care medical visits (as defined above) are being missed. In BridgeIT, there are UDS Validation reports for this purpose (usually run at the end of the year). In Relevant, understand well the tranformers that define UDS visits.

1. **The Timing of Positive Depression Screens**

Report: Depression Screening and Followup

Issue: For patients who are screened multiple times during the measurement period, which screenings should be examined by the report?

Description: Patients with several visits can be screened for depression several times, with potentially a mix of results. Below is a hypothetical situation. How would the depression measure be evaluated for this patient?



1. Option #1: the patient should not be included in the numerator because there was no follow-up to the first positive screen in the 2018 measurement period.
2. Option #2: the patient should be included the numerator because the patient was screened in the measurement period and the first screen was negative.
3. **Patients Declining Depression Screens or Followup**

Report: Depression Screening and Followup

Issue: The 2018 UDS instructions allow denominator exclusions for patients who “refuse to participate” (page 95). Can we agree that health centers can document patients who decline to be screened for depression or decline any kind of follow-up activity and that this would count as an exclusion to the denominator?

Description: eCW Version 11 contains changes to the depression screening and followup templates. One change is that they are allowing the use to enter that a patient declines screening. Because not all health centers have version 11 yet (and Ben has not tested it), we do not have all the details. Some health centers have also built this option into structured data. In any case, this should be something built into the measure for whatever health record or reporting system you use.