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

September 9, 2019 Meeting

Version 1, By Ben Fouts MPH, RCHC Data Analyst

1. **Proposed Measures for the Partnership HealthPlan Quality Initiative**

Possible Report Set: Additions to the 2020 QIP Report Set

Issue: Partnership Healthplan is adding some new measures to the QIP Report Set. These have been discussed at an executive level, but no official instructions have been released. The information below is a “heads-up” about our current understanding of these measures. The details come from official HEDIS documentation and may be slightly modified by Partnership in the final instruction manual.

Description: This is a list of the new measures.

Family Practice:

1. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
2. Adolescent Well-Care Visits (AWC)
3. Childhood Immunization Status (CIS). NOTE: the 2019 QIP measure will be modified to meet the new definition

Pediatric Practice:

1. Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Pay for Service:

1. AFQ Standard Screening
2. Screening for exposure to trauma (ACES)

Further Detail:

| Measure Name | Brief Definition |
| --- | --- |
| Denominator | Numerator | Exclusion |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life  | Children 3 to 6 years of age | Number of patients with one or more well visits in the measurement period |   |
| Adolescent Well-Care Visits  | Adolescents 12 to 21 years of age | Number of patients with one or more well visits in the measurement period |   |
| Childhood Immunization Status | Children 2 years of age | 24 doses of 10 required vaccines by 2nd birthday (this is the same as the UDS definition) | Contraindication to vaccine or history of illness |
| Follow-Up Care for Children Prescribed ADHD Medication (Acute and Continuation Rates) | 6 to 12 years of age with diagnosis of ADHD and newly prescribed an ADHD medication | - Acute rate: follow-up visit within 30 days of new prescription- Continuation rate: two follow-up visits within 270 days of new prescription (if on the med for more than 210 days) | Narcolepsy |

Relevant Quality Measure reports will be produced for the new measures. We may also need to discuss standardization issues in a future Data Standards and Integrity Committee meeting.

1. **Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**

Report Set: 2019 UDS Report

Issue: Relevant is creating a new Quality Measure for this new UDS measure, which replaces the 2018 measure “Coronary Artery Disease (CAD): Lipid Therapy.” Below is a detailed description of the measure using value set codes. It is being mentioned here because of its complexity.

Description: All of the components of the denominator can be determined though codes. The numerator is composed of patients using a statin medications in the past year, which can also be determined through codes (see section C below).

The denominator is composed of three populations (evaluated in the order below).

**Denominator Population 1:** Patients aged 21 years or older at the beginning of the measurement period with clinical (ASCVD). ASCVD is defined as a union of all of the following code sets:

* Diagnosis: Myocardial Infarction [value set 2.16.840.1.113883.3.526.3.403]
* Diagnosis: Cerebrovascular disease, Stroke, TIA [value set 2.16.840.1.113762.1.4.1047.44]
* Diagnosis: Atherosclerosis and Peripheral Arterial Disease [value set 2.16.840.1.113762.1.4.1047.21]
* Diagnosis: Ischemic heart disease or coronary occlusion, rupture, or thrombosis [value set 2.16.840.1.113762.1.4.1047.46]
* Diagnosis: Stable and Unstable Angina [value set 2.16.840.1.113762.1.4.1047.47]
* Procedure: PCI [value set 2.16.840.1.113762.1.4.1045.67]
* Procedure: CABG Surgeries [value set 2.16.840.1.113883.3.666.5.694]
* Procedure: Carotid Intervention [value set 2.16.840.1.113883.3.117.1.7.1.204]

**Denominator Population 2:** Patients aged 21 years or older at the beginning of the measurement period who meet either of the following conditions for high blood cholesterol:

1. Have ever (in patient history) had a fasting or direct LDL-C laboratory test [value set 2.16.840.1.113883.3.464.1003.198.11.1029] result of greater than or equal to 190 mg/dL, or;
2. Were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia [value set 2.16.840.1.113762.1.4.1047.100].

**Denominator Population 3:** Patients between 40 and 75 years of age at the beginning of the measurement period who have a diagnosis of diabetes [value set 2.16.840.1.113883.3.464.1003.103.12.1001 ] with a fasting or direct LDL-C laboratory test [value set 2.16.840.1.113883.3.464.1003.198.11.1029] result of 70 to 189 mg/dL in the three years prior to the end of the measurement period. However, exclude patients from this population if the last fasting or direct LDL-C laboratory test prior to the end of the measurement period had result of under 70 mg/dL and the patient was not using statins.

**Denominator exclusions** (for any of the three populations):

* Diagnosis: Pregnant at any time during the Measurement Period [value set 2.16.840.1.113883.3.600.1.1623]
* Diagnosis: breastfeeding at any time during the Measurement Period [value set 2.16.840.1.113762.1.4.1047.73]
* Diagnosis: Rhabdomyolysis [value set 2.16.840.1.113762.1.4.1047.102]

**Denominator exceptions** (for any of the three populations):

* Palliative Care Order or Encounter [value set 2.16.840.1.113883.3.600.1.1575]
* Diagnosis: End Stage Renal Disease [value set 2.16.840.1.113883.3.526.3.353]
* Diagnosis: Hepatitis A [value set 2.16.840.1.113883.3.464.1003.110.12.1024]
* Diagnosis: Hepatitis B [value set 2.16.840.1.113883.3.67.1.101.1.269]
* Diagnosis: Liver Disease [value set 2.16.840.1.113762.1.4.1047.42]
* Adverse reaction, allergy or intolerance to Statins [no value set, from structured data]

**Numerator** is composed of patients with an active medication or order for:

* High intensity statin therapy [value set 2.16.840.1.113762.1.4.1047.97]
* Moderate intensity statin therapy [value set 2.16.840.1.113762.1.4.1047.98]
* Low intensity statin therapy [value set 2.16.840.1.113762.1.4.1047.107]
1. **Standardizing Medication Definitions for the Quality Measures**

Possible Report Sets: UDS and QIP reports that identify medications

Issue: Up to this point, there has been no standard way to identify medications in the EHR electronically, and so health centers have been spending lots of time maintaining medication groups or identifying medication names for hard-coding into SQL queries. As a group, the Data Standards and Integrity committee should decide to perhaps take a more standard approach when one becomes available.

Description: Relevant is nearing completion of a ‘crosswalk’ between the NDC codes that appear in the electronic health records (i.e., eCW and NextGen) and the Rx Norm codes that appear in the Value Sets.

Here is how that crosswalk would work:



Further Detail: Below are the Value Sets that would be used in the reports.

|  |  |  |  |
| --- | --- | --- | --- |
| Report Set | Measure | Medication Description | Value Set Name (If Applicable) |
| UDS | Use of Appropriate Medications for Asthma | Preferred Asthma Therapy | 2.16.840.1.113883.3.464.1003.196.12.1212 |
| Tobacco Use: Screening and Cessation Intervention | Tobacco Use Cessation Pharmacotherapy | 2.16.840.1.113883.3.526.3.1190 |
| Screening for Depression and Follow-Up Plan | Depression medications - adult | 2.16.840.1.113883.3.600.470 |
| Depression medications - adolescent | 2.16.840.1.113883.3.600.469 |
| IVD and use of Aspirin or another antiplatelet | Aspirin and Other Antiplatelets | 2.16.840.1.113883.3.464.1003.196.12.1211 |
| Anticoagulant Medications | 2.16.840.1.113883.3.464.1003.196.12.1283 |
| Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | High intensity statin therapy | 2.16.840.1.113762.1.4.1047.97 |
| Moderate intensity statin therapy | 2.16.840.1.113762.1.4.1047.98 |
| Low intensity statin therapy | 2.16.840.1.113762.1.4.1047.107 |
| QIP | Nephropathy Screening Test Among Patients With Diabetes | [[1]](#footnote-2)Evidence of ACE inhibitor/ARB therapy | ACE Inhibitor/ARB Medications Value Sets |
| Asthma Medication Ratio | Asthma Controller Medications | Asthma Controller Medications Value Set |
| Asthma Reliever Medications | Asthma Reliever Medications Value Set |

Ben is working on a Relevant validation report that would display lists of medication names that belong to each Value Set.

1. **Definition of Patients With Persistent Asthma**

Report Set: UDS and QIP reports that identify patients with persistent asthma

Issue: There should be agreement on the best way to handle patients with both an intermittent asthma diagnosis code and a persistent asthma diagnosis code currently on the Problem List.

Description: A portion of patients at most health centers have both intermittent and persistent asthma diagnosis codes on the Problem List. The Transformer “asthma\_cases” rightfully pulls all patients with any asthma code, and then displays TRUE/FALSE if the code is a persistent asthma code, along with a “started on” date.

The “Use of Appropriate Medications for Asthma” Quality Measure then takes the asthma code from the Problem List with the most recent “started on” date as the asthma diagnosis to evaluate. If that diagnosis code is persistent, the patient is included in the denominator (along with other criteria). If that diagnosis code is intermittent, the patient is not considered for the denominator. Below (Method #1) is another explanation of the approach that is currently being used in Relevant.

Asthma Diagnosis Evaluation **Method #1**

1. For each patient, pull all asthma codes and classify them into persistent or intermittent asthma groups (Transformer level)
2. Take the code with the most recent “started\_on” date and the asthma group associated with it (QM level)
3. If that asthma group is persistent, include the patient in the measure denominator. If that asthma group is intermittent, do not include in the measure denominator (QM level)

Therefore, among patients with both intermittent and persistent asthma diagnosis codes on the Problem List, some are included in the denominator and some not depending on the order in which the codes were entered.

Some important questions arise from this approach. Is there any clinical reason why a patient could legitimately have both kinds of codes? Are patients with a persistent asthma diagnosis typically not treated for persistent asthma after an intermittent asthma diagnosis is added to the Problem List? In other words, is it reasonable to expect any patient with any active persistent asthma code on the Problem List to be treated with the preferred medication therapy described by the measure, or is this negated by the addition of an intermittent asthma diagnosis?

Another possible approach to defining patients with persistent asthma is below (Method #2)

Asthma Diagnosis Evaluation **Method #2**

1. For each patient, pull all asthma codes and classify them into the persistent or intermittent asthma group (Transformer level)
2. Include any patient with a persistent diagnosis in the denominator

Here is a summary comparison of both methods.

|  |  |
| --- | --- |
| **Patient population** | **Patient included in denominator** |
| **Method #1** | **Method #2** |
| Patients with only persistent code(s) | Yes | Yes |
| Patients with only intermittent code(s) | No | No |
| Patients with both persistent and intermittent code(s) | Some yes and some no, depending on order of diagnosis | Yes |

For the Data Standards and Integrity participants: Are there any other possible methods?

Which method makes the most sense can depend on the clinical guidelines used in your health center, but also the existing data in the EHR. There is some data on the next page that will be discussed. **However, it is important to note right now that health centers should not immediately change their Transformers or QM based on our discussion today.** This topic is being brought up so that further investigation can be performed and we can deliberate on the issue. All health centers will be given an opportunity to weigh-in on the issue so that we can all take a standardized approach together. Also, the data and the issue are being presented today for your information only. RCHC is not necessarily saying the current approach is wrong or that your data is wrong. This topic is being presented so we can better understand our data regardless of what is ultimately decided.

On the next page is a table with data from all of the Relevant health centers. The focus of this data is on patients with active codes from both asthma diagnosis groups (described as “duals” in the table, for lack of a better term). Two health centers have no patients with a dual diagnosis but others have many. Of all patients with a dual diagnosis, almost 43% were considered “intermittent” by Method #1 (above). If these patients are added to the denominator, they will account for almost a quarter of patients overall. Therefore, this issue is not insignificant for the denominator. However, the numerator (i.e., using a preferred medication) among dual patients considered “intermittent” by Method #1 is nearly the same for all health centers together (81.4%) as the currently-defined measure (81.8%) for the same time period (i.e., the year ending July 31, 2019). Therefore, if we added these duals considered intermittent, we would raise the denominator by 11.8% for all health centers, but not effect the numerator significantly (only 0.04% overall).

Health centers should look at their own data for this issue. SQL code has been added by Ben Fouts to the Slack Channel that can be used to identify these kinds of “dual” patients. It is recommended that health centers look at some of these patients in their EHR to get a sense of why they have both diagnosis codes, and if it is correct to leave them in or out of the denominator of the report. During the next Data Standards and Integrity meeting, we would like to hear from health centers on their findings and opinions of Method #1 vs. Method #2 for identifying patients with persistent asthma.

Note that “Resolving” (in eCW) one diagnosis or the other would solve the issue, depending on what the clinician concludes is best diagnosis for a particular patient. This can possibly be added to the Relevant SQL code in the Transformer. Such an approach seems like a solution because it gives the power of making a clinical decision back to the provider. However, providers reviewing patients uses time.

Further Detail: A study was done to estimate the number of patients who might be impacted by a change in the persistent asthma identification method and how that would influence the measure’s end results. In a way, this is evaluating a change to Method #2 from the previous pages (i.e., considering patients as having persistent asthma if any persistent asthma code appears on the Problem List regardless of the presence of an intermittent code and order entered).

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Health Center | Number of patients with both asthma codes\* | All duals as a percentage of potential denominator \*\* | Proportion of duals considered intermittent by the current asthma QM | Of duals considered intermittent by the current asthma QM, the percentage that meet numerator criteria | Current UDS asthma QM numerator (until end of July 31, 2019) | The new numerator If intermittent duals are added | **End result:** denominator difference if intermittent duals are added  | **End result:** numerator difference if intermittent duals are added |
| Ole | 79 | 16.0% | 39.2% | 90.3% | 77.3% | 78.1% | 6.7% | 0.8% |
| CommCare | 51 | 20.7% | 52.9% | 96.3% | 84.5% | 85.8% | 12.3% | 1.3% |
| Winters | 8 | 36.4% | 50.0% | 75.0% | 94.4% | 90.9% | 22.2% | -3.5% |
| Santa Rosa | 284 | 22.4% | 46.5% | 65.9% | 68.5% | 68.3% | 11.6% | -0.3% |
| Marin City | 8 | 20.0% | 25.0% | 50.0% | 68.4% | 67.5% | 5.3% | -0.9% |
| Marin Comm | 377 | 80.2% | 39.5% | 85.9% | 88.8% | 87.9% | 46.4% | -0.9% |
| Alex Valley | 2 | 5.9% | 50.0% | 100.0% | 87.9% | 88.2% | 3.0% | 0.4% |
| Coastal | 18 | 32.7% | 100.0% | 100.0% | 86.5% | 90.9% | 48.6% | 4.4% |
| Sonoma Valley | 0 | 0% | -- | -- | 90.7% | -- | 0.0% | 0.0% |
| SCIHP | 9 | 10.3% | 33.3% | 66.7% | 95.2% | 94.3% | 3.6% | -1.0% |
| Ritter | 0 | 0% | -- | -- | 60.9% | -- | 0.0% | 0.0% |
| Petaluma\*\*\* | 97 | 12.0% | 32.0% | 96.8% | 96.5% | 96.5% | 4.0% | 0.0% |
|  | 933 | 24.7% | 42.7% | 81.4% | 81.8% | 81.7% | 11.8% | 0.0% |
|  |  |  |  |  |  |  |  |  |
| eCW | 547 | 18.3% | 45.0% | 78.9% | 79.8% | 79.7% | 9.0% | -0.1% |
| NextGen | 386 | 49.2% | 39.4% | 85.5% | 90.3% | 89.4% | 24.1% | -0.9% |

\* These are patients who otherwise met the criteria for the UDS asthma measure in terms of visits and exclusions (the measurement period was one year, ending on July 31, 2019). For lack of a better term, these patients are called “duals” in this table.

\*\* If all duals were also considered part of the asthma measure denominator, what would be their proportion in that denominator

\*\*\* Data for Petaluma is for illustrative purposes only; they are using a non-standard transformer. Data analyzed separately so that it can be compared in this table.

1. [↑](#footnote-ref-2)