New ECDS Measures: Focus on Relevant Quality Measures

RCHC Data Workgroup Webinar

By Ben Fouts, RCHC Data Analyst

August 9, 2022

Agenda

- Introduction and Available Resources
- General Characteristics of the ECDS Quality Measures
- Overlapping Measures: Existing Quality Measures
- Overlapping Measures: New MCAS Measures
- Non-Overlapping New ECDS Measures

Introduction and Available Resources

From Previous Discussions

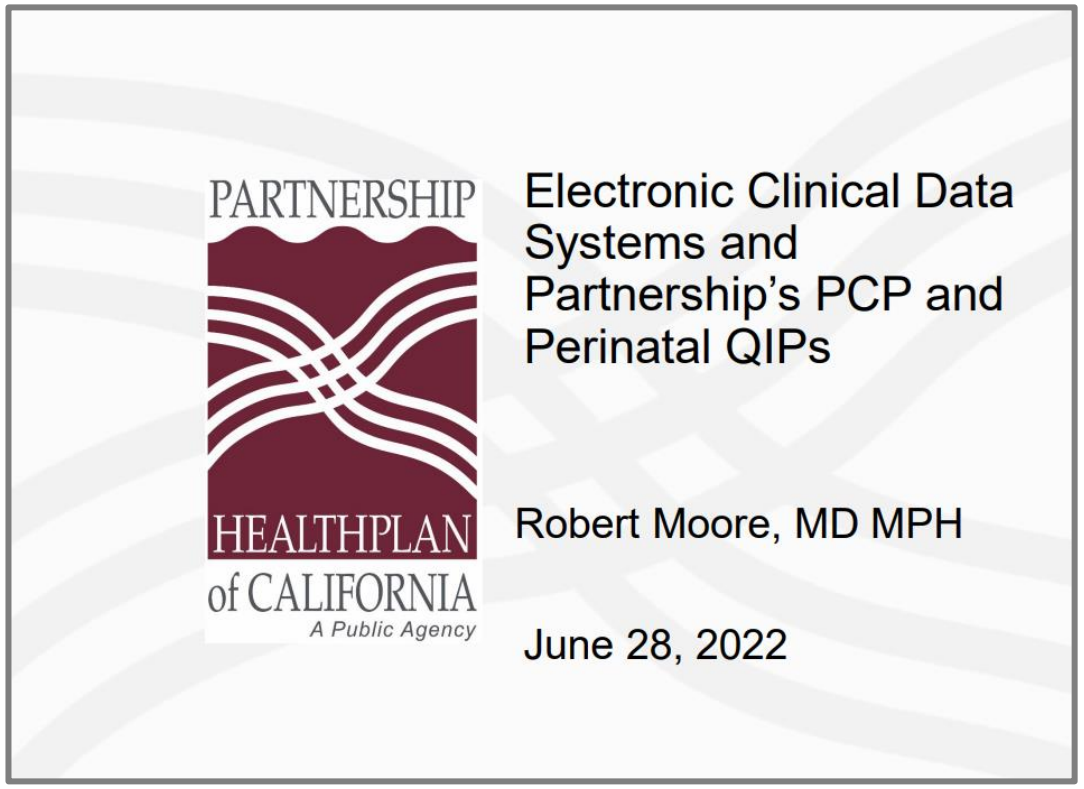
Introduction (Data Report Project)

- Health centers have an opportunity to participate in a pilot program to securely send Partnership HealthPlan patient data so that they can more accurately report a number of HEDIS measures
- A report set has been developed by RCHC to extract patient data. Health centers need to customize and validate the reports before submitting the data
- The 2022 incentive to participate is $5,000
- Data submission will be mandatory in 2023

Introduction (Associated Quality Measures)

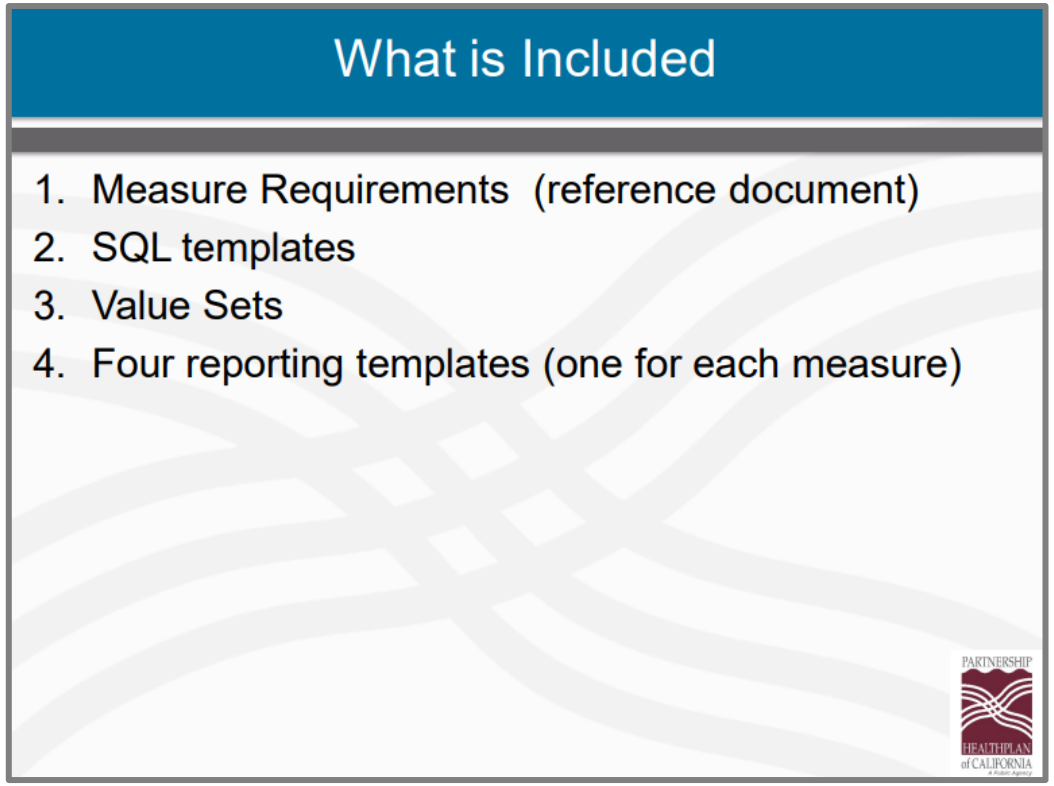
- The data submissions support the evaluation of a set of eight HEDIS measures
- Two of the measures have more than one numerator
- In all, there is a set of eleven Quality Measures in Relevant

Partnership ECDS Materials



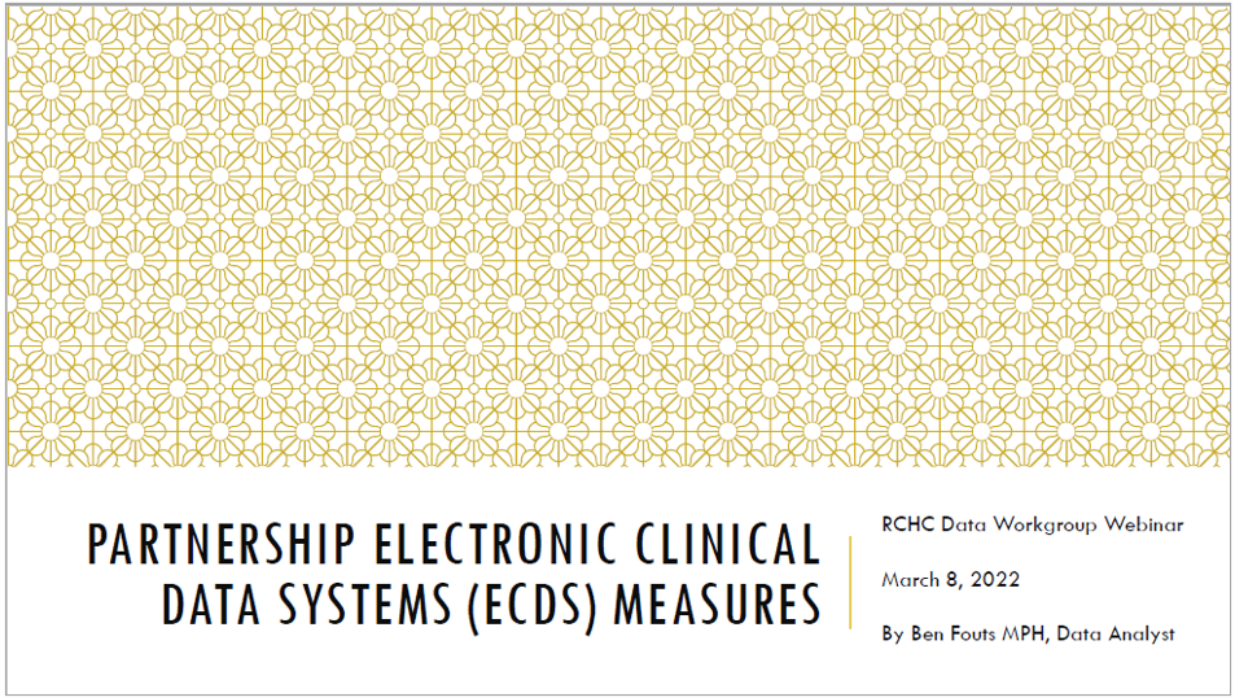
The data submission supports Partnership's evaluation of the measures, but is not the measurement itself

Contains overview of the quality measures but focuses mostly on the data submission instructions

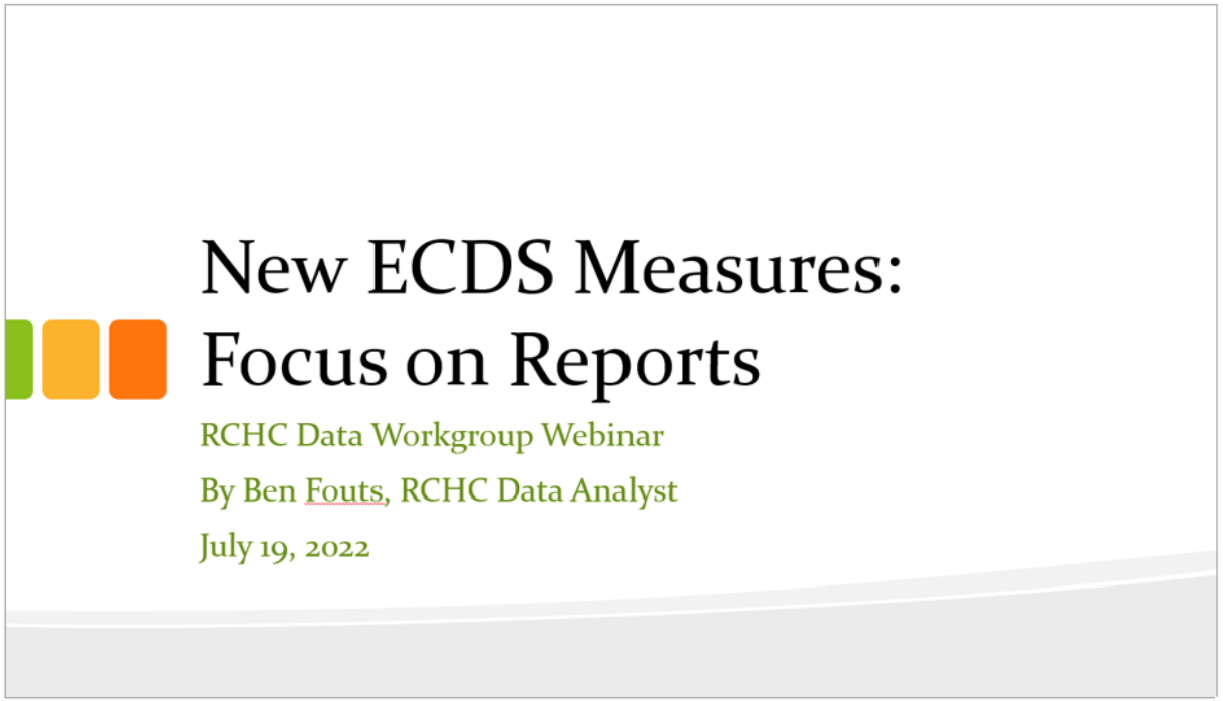


Previous Data Workgroup Webinars

Slide presentations and recordings available on the rchc.net website



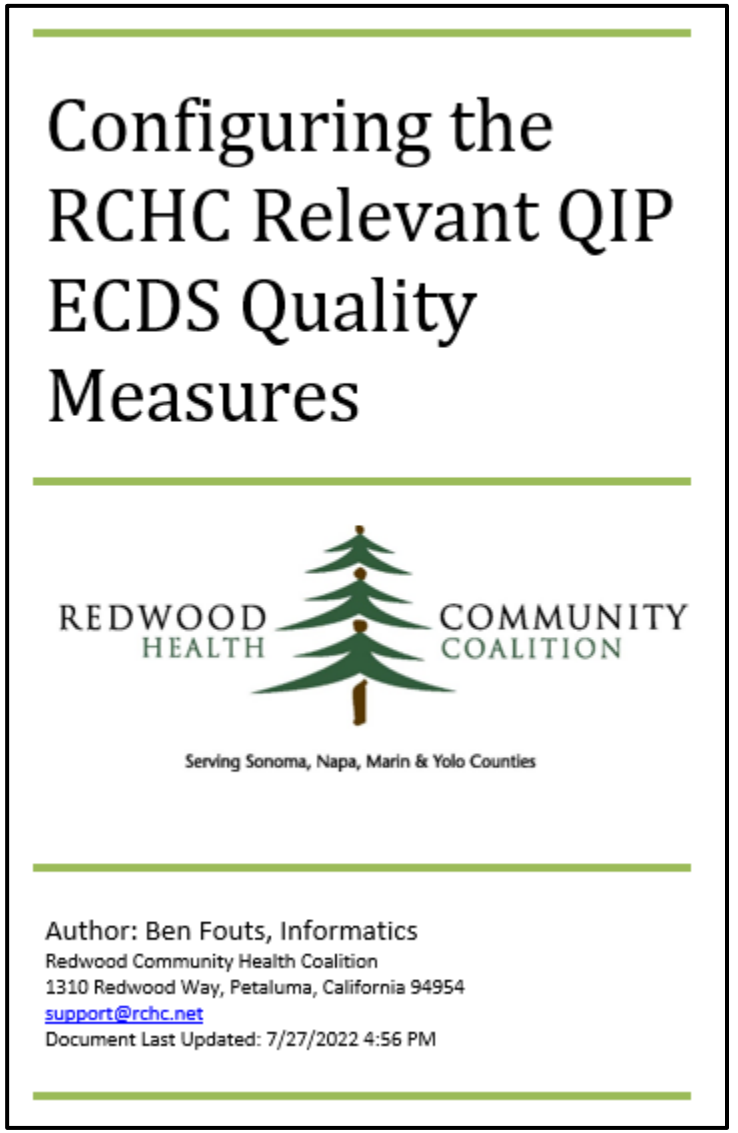
March 2022



July 2022

New Instruction Manual

- Instructions on setting-up the quality measures and related Transformer/Data Element pairs
- Contains initial draft of SQL code and explanation of the correct approach for these items
- Watch for an announcement e-mail from RCHC



Characteristics of the ECDS Quality Measures

General Approach and Design

Population for ECDS Quality Measures

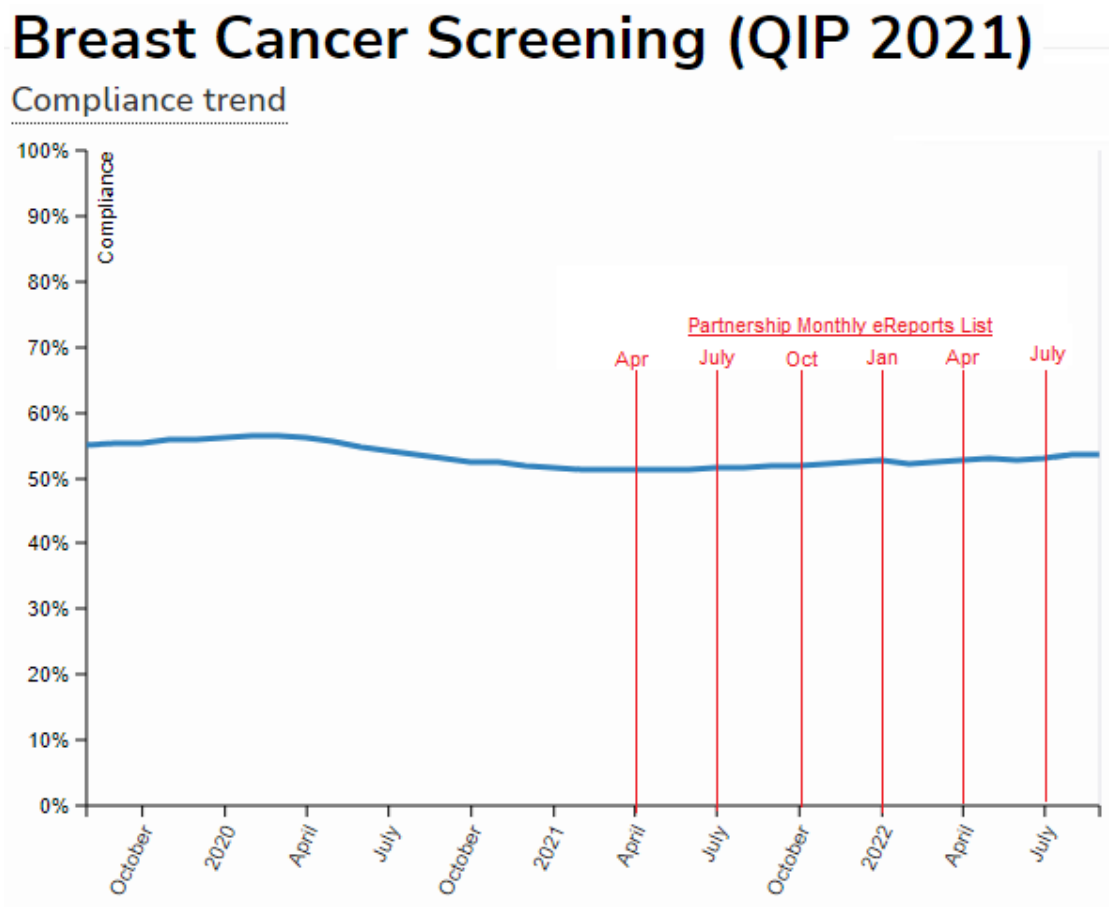
- The measures have a similar design as the QIP report set developed by RCHC
- The default version evaluates ALL patients who qualify for the denominator
- Health centers can decide to have the measures focus on all patients, focus only current Partnership patients, or have two versions of the measure to track both populations

Partnership Specific Population

The health center can choose to modify the Quality Measure (or make a modified copy) that is specific to Partnership patients:

- Option #1: Restrict to patients who have Partnership insurance (i.e., by group or by specific insurance names)
- Option #2: Directly JOIN the Universe temporary table to the Partnership eReports list for the identified month (see next slide)
- Option #3: other ideas?

Denominator Month-to-Month



- Remember that the Quality Measure is a series of denominators (one per month) and so historically accurate data is necessary. In other words, who were the Partnership patients in the particular past month?
- For a specific month in the past, this should not change as time moves forward

Overlapping Measures

- ECDS + UDS + QIP + HEDIS + eCQM + MCAS
- Health Centers do not necessarily need to have copies of Quality Measures for each reporting source if they display exactly the same data

ECDS Measure Set (and Overlaps)

Overlaps UDS and/or QIP Quality Measures

- Beast Cancer Screening (BCS)
- Depression Screening and Follow up (DSF)

Overlaps MCAS (State of California Medicaid) Measures

- Prenatal Depression Screening and Follow-Up (PND
- Post-partum Depression Screening and Follow-Up (PDS)

ECDS Measure Set (and Overlaps)

New ECDS Measures (Based on HEDIS Definitions)

- Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)
- Depression Remission or Response for Adolescents and Adults (DRR)*
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF)

** This measure has a different definition than the UDS Measure "Depression Remission at Twelve Months" (CMS159v10)*

Established Measures: Beast Cancer Screening (BCS) and Depression Screening and Follow up (DSF)

Overlapping Measures: Existing Quality Measures

Established Quality Measures

Breast Cancer Screening (QIP 2021)

The percentage of female patients age 52 to 74 years who had appropriate breast cancer screening.

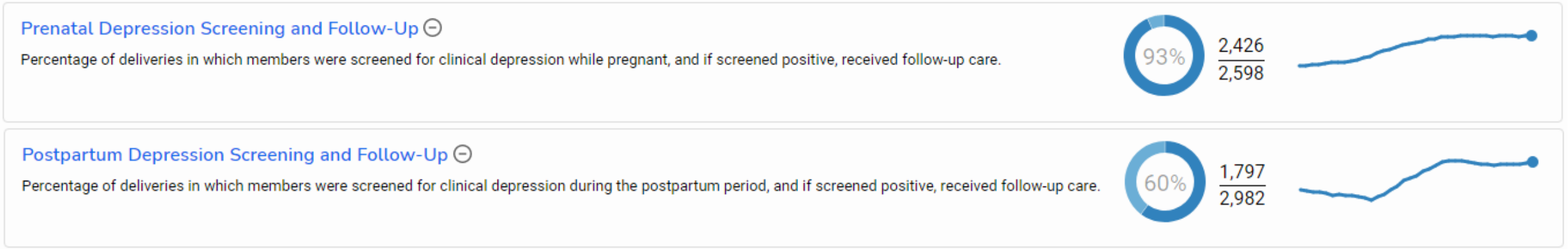
Preventive Care and Screening: Screening for Depression and Follow-Up Plan (UDS 2022 Table 6B)

Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool **and**, if screening was positive, had a follow-up plan documented on the date of the visit

MCAS Measures: Prenatal Depression Screening and Follow-Up (PND) and Postpartum Depression Screening and Follow-Up (PDS)

Overlapping Measures: New MCAS Measures

From the new MCAS Measure Set



Wait for further instruction on when these are to be finalized

The Medi-Cal Managed Care Accountability Set (MCAS) has over 20 measures and is being developed for RCHC by Relevant

Measure Definition

- Very similar to the Quality Measure "Preventive Care and Screening: Screening for Depression and Follow-Up Plan"
- But the focus is on specific populations: prenatal patients and postpartum patients
- In both cases, the population is initially defined as patients who have a delivery date (i.e., pregnancy_deliveries.delivered_on) in a specified intake period
- It is therefore essential that health centers continue their data quality efforts to ensure that delivery dates are being entered into the EHR

Measure Definition

- **Prenatal** patients must be screened for clinical depression during pregnancy using a standardized instrument. If there is a positive depression screen finding, follow-up care must occur **within 30 days** of the finding
- **Postpartum** patients must be screened for clinical depression during the postpartum period (i.e., delivery date through 60 days following the date of delivery) using a standardized instrument. If there is a positive depression screen finding, follow-up care must occur **within 30 days** of the finding

Transformers/Data Elements

- As discussed in the July Data Workgroup presentation for the ECDS Data Reports, the Edinburgh Postnatal Depression Scale (EPDS) is an approved depression screening instrument
- If your health center uses the EPDS and enters the result into structured data, then create a Transformers/Data Element pair to extract this data.
- There is a new Data Element “Edinburgh Depression Screens”
- Example code exists in the RCHC Relevant QIP ECDS Quality Measures Instruction Manual
- See July 2022 Data Workgroup presentation for additional detail

Non-Overlapping New ECDS Measures

- Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)
- Depression Remission or Response for Adolescents and Adults (DRR)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF)

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)

Follows HEDIS Definition

Monitoring Depression Symptoms

- HEDIS: “Guidelines for adults recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms”
- Measure description: The percentage of patients 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.

Quality Measure Definition

"…PHQ-9 score present in their record in the same assessment period as the encounter…"

- Assessment Period 1: January 1–April 30
- Assessment Period 2: May 1–August 31
- Assessment Period 3: September 1–December 31

In Relevant, an "encounter" is defined as a UDS Medical or UDS Behavioral Health visit

Approach to Assessment Periods

- If the patient had a visit in the specific Assessment Period, the measure looks to see if there was also a PHQ-9 in the same period
- One approach considered but NOT taken: make three different Quality Measures for the three Assessment Periods. But it seems weird to have a measure look at something that happened, say, 8 to 12 months ago

Relevant Measure Approach

- Assessment Periods are evaluated separately but results added together
- A patient can have a visit in one, two or three Assessment Periods
- The measure numerator evaluates if the patient had a PHQ-9 in **all** Assessment Periods with at least one visit
- The numerator is additive in that it looks back over all three Assessment Periods. To be in the overall numerator, the patient must have a PHQ-9 in **all** Assessment Periods with at least one visit
- No new Transformers or Data Elements are required for this measure

Example Data

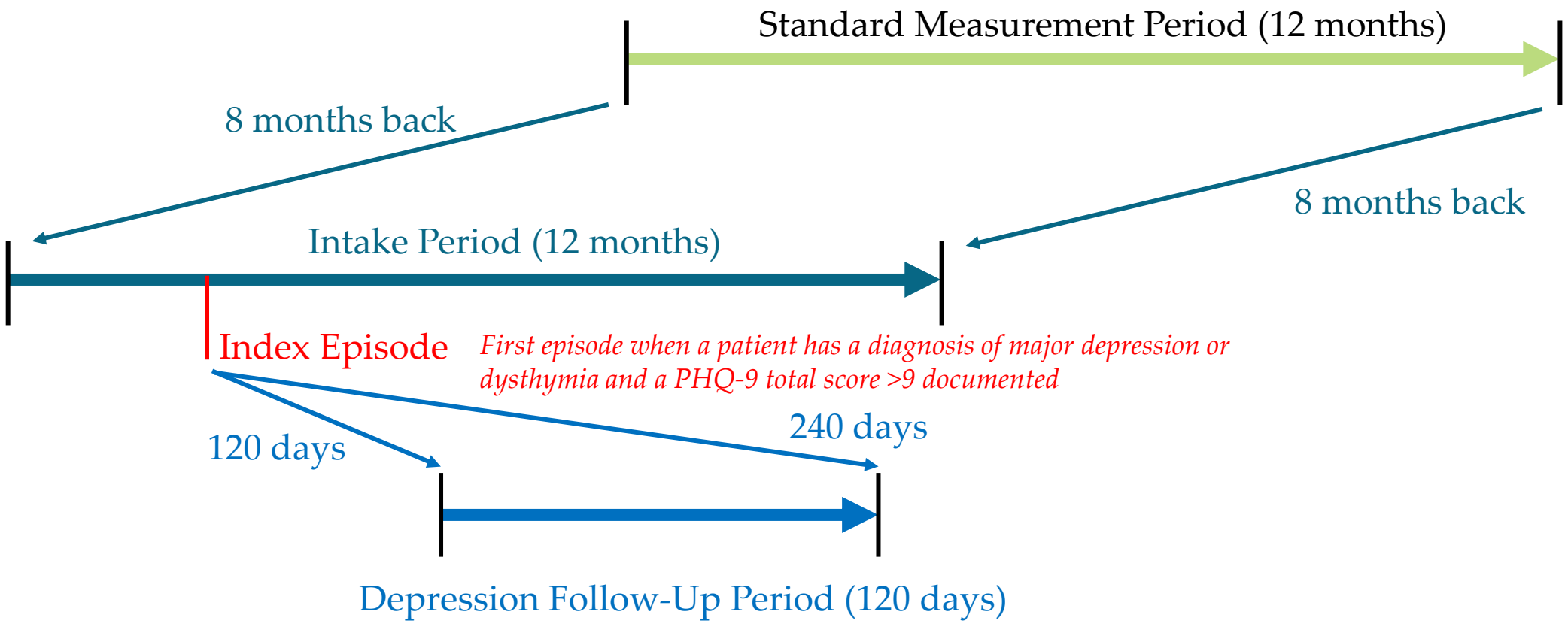
Rough data from the Measurement Period 8/1/2021 to 7/31/2022

	Average Across All Three Assessment Periods		
	Percentage of Annual Patients Seen in Assessment Period	Percentage Patients Seen in Assessment Period With a PHQ-9	Measure Numerator
Health Center #1	72.3%	22.1%	9.9%
Health Center #2	66.8%	23.4%	9.1%
Health Center #3	69.4%	34.3%	20.6%
Health Center #4	64.6%	56.3%	36.8%

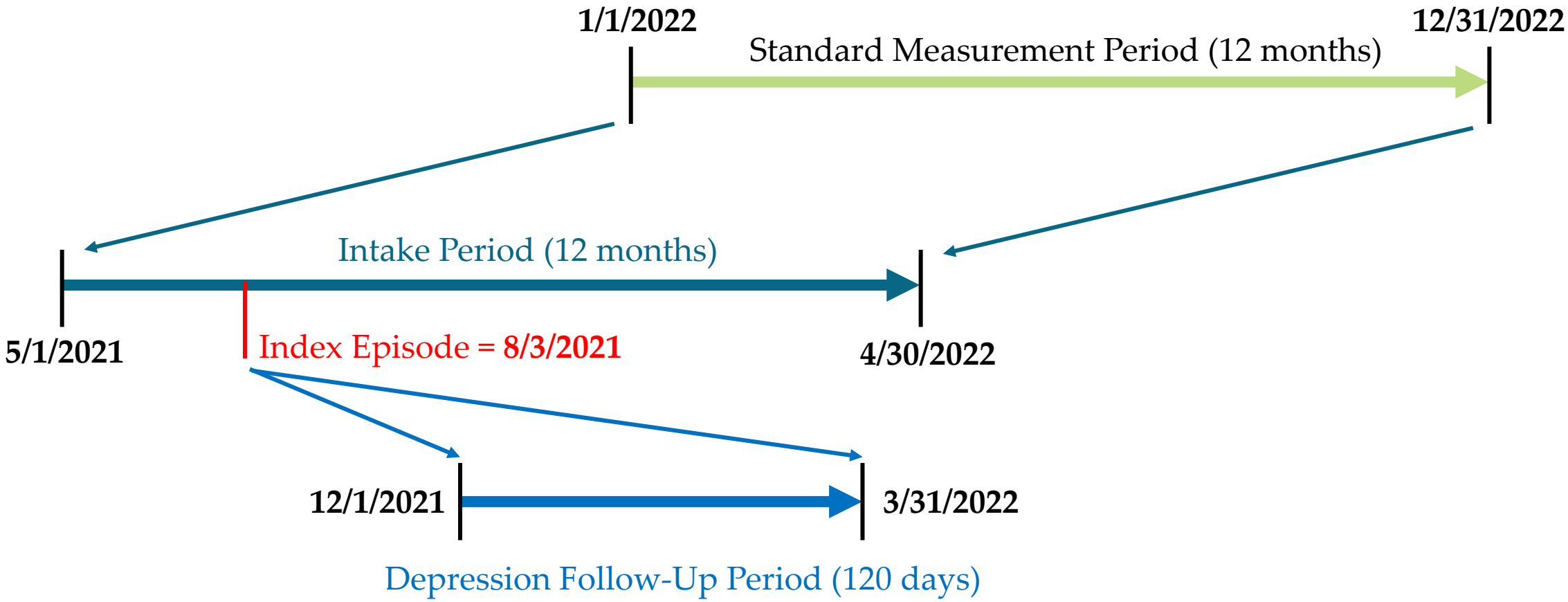
Depression Remission or Response for Adolescents and Adults (DRR)

Follows HEDIS Definition

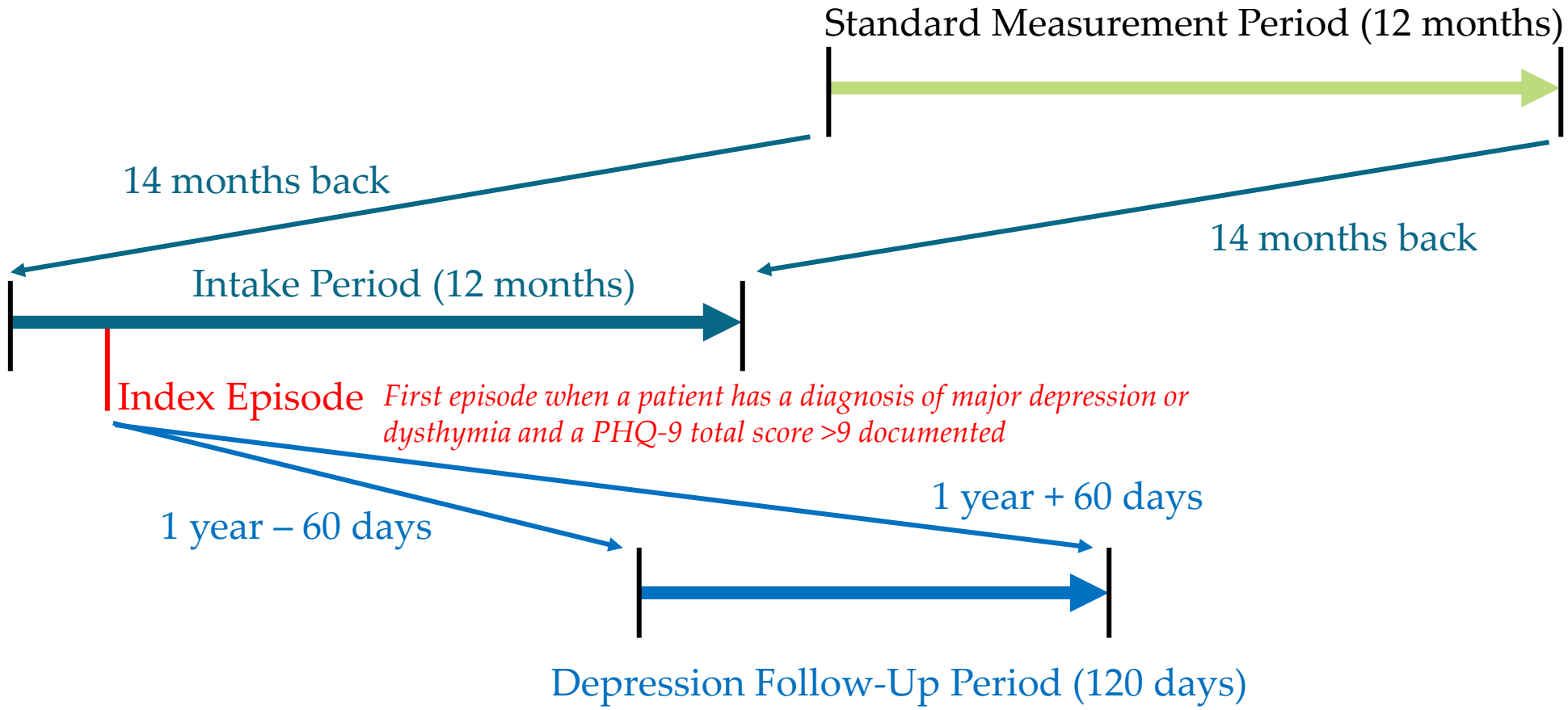
Logic Model for the Measure



Logic Model With Example Dates



Compare to UDS Depression Remission at Twelve Months (CMS159v10)



Compare UDS to QIP

- The UDS Intake Period is further back in time relative to the Measurement Period (14 months vs. 8 months)
- The UDS Depression Follow-Up Period is further in the future from the Index Episode (1 year +/- 60 days vs 120 to 240 days)
- The overall result is that more patients could be lost to follow-up but more patients who stay with treatment have an opportunity to respond to treatment

- Hypothesis: the ECDS QIP measure will have a higher denominator

  BUT a lower numerator than the UDS measure

ECDS Denominator Definition

- Patients 12 years and older at the start of the Intake Period
- A diagnosis of major depression or dysthymia that starts before or on the date when the PHQ-9 total score >9 is documented during the Intake Period
- No exclusions:
  - ✓ Bipolar disorder
  - ✓ Personality disorder
  - ✓ Psychotic disorder
  - ✓ Pervasive developmental disorder
  - ✓ In hospice or using hospice services during the measurement period

Three Numerators in Three Quality Measures

1. **Follow-Up PHQ-9**. The percentage of denominator patients who have a follow-up PHQ-9 score documented during the Depression Follow-Up Period
2. **Depression Response.** The percentage of denominator patients who showed response during the Depression Follow-Up Period. This is defined as the most recent PHQ-9 during the Follow-Up Period having a score at least 50% lower than the score of the Index Episode PHQ-9
3. **Depression Remission.** The percentage of denominator patients who achieved remission during the Depression Follow-Up Period. This is defined as the most recent PHQ-9 during the Follow-Up Period having a score of less than 5

Names of Quality Measures

- Depression Remission or Response for Adolescents and Adults: **Follow-Up PHQ-9** (Aligns with HEDIS Measure DRR)
- Depression Remission or Response for Adolescents and Adults: **Depression Response** (Aligns with HEDIS Measure DRR)
- Depression Remission or Response for Adolescents and Adults: **Depression Remission** (Aligns with HEDIS Measure DRR)

Notes on Follow-Up PHQ-9

- This is dependent on your follow-up procedures. Are patients with elevated PHQ-9 and a depression/dysthymia diagnosis being recalled or otherwise seen frequently in the clinic?
- Are they always getting a PHQ-9 when they come in?
- This is similar to the measure "Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults." That measure looks to see if patients with a depression/dysthymia diagnosis have a PHQ-9 in a defined 4-month period
- The Follow-Up PHQ-9 measure also looks to see if the patients have a PHQ-9 in a defined 4-month (aka, 120-day) period

Notes on Depression Remission and Depression Response

- No new Transformers/Data Elements are needed for this measure
- Note that the "Follow-Up PHQ-9" is a process measure and the other two are outcome measures
- The outcome measure for "Depression Remission" is similar to the UDS measure in that the follow-up PHQ-9 must have a score of under 5
- Health centers can now follow an alternate outcome using the measure for "Depression Response" (i.e., if the follow-up PHQ-9 had a score 50% or less compared to the Index PHQ-9 score)

Follow-up Care for Children Prescribed ADHD Medication (ADD)

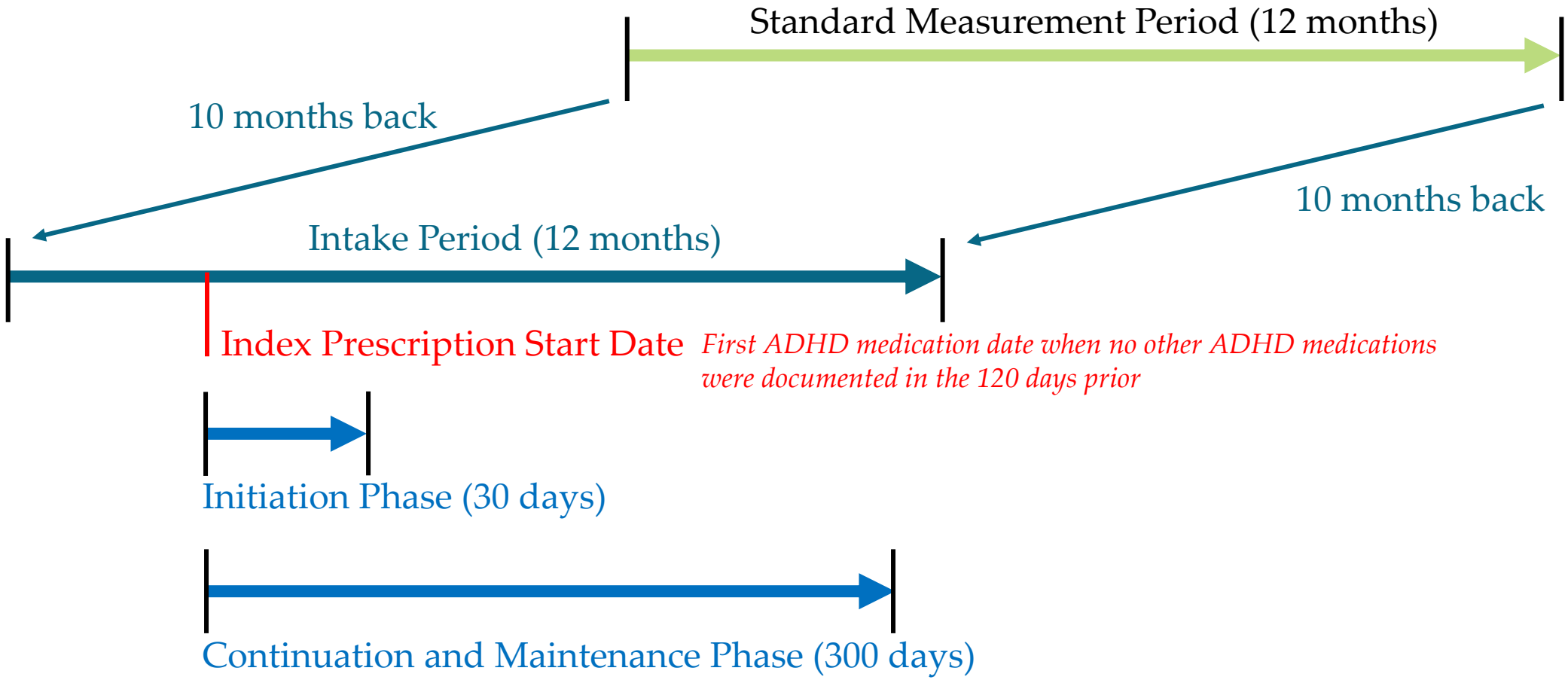
Follows HEDIS Definition

Basic Premise

- Clinical recommendations by the American Academy of Child and Adolescent Psychiatry (AACAP)
- Children newly prescribed ADHD medications should have a treatment plan and be monitored for treatment-emergent side effects
- Patients should be assessed periodically to determine whether there is continued need for treatment or if symptoms have remitted

- Therefore, the measure focuses on children newly prescribed ADHD medications and if they are getting follow-up visits

Logic Model for the Measure



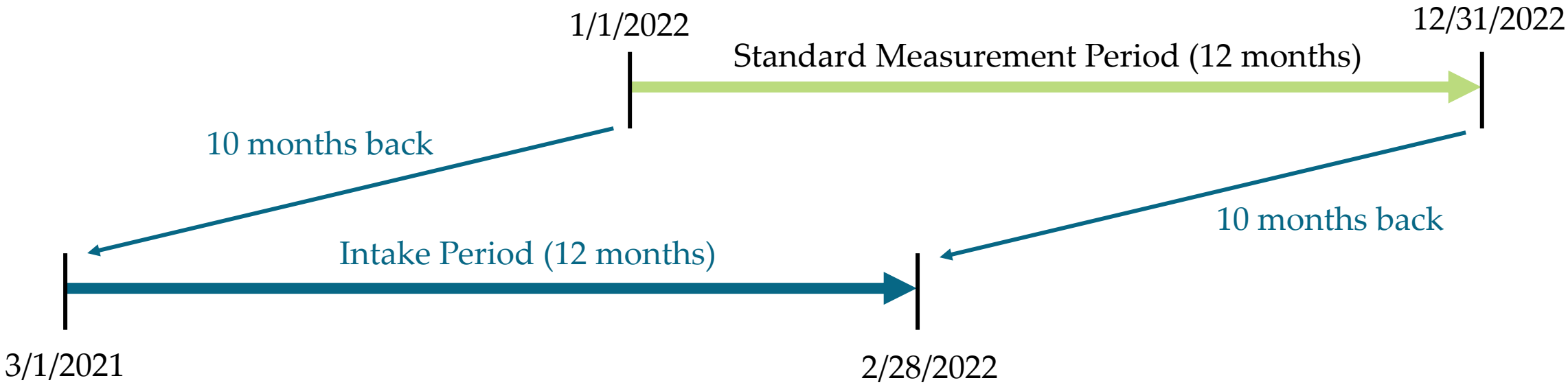
Denominator Definition

- Patients with a visit in the standard Measurement Period
- Children 6 years of age as of the start of the Intake Period to 12 years of age as of the end of the Intake Period
- Had an ADHD medication in the Intake Period with no medication history (more detail on upcoming slide)
- No exclusions: narcolepsy or hospice services

Other Definitions

Intake Period

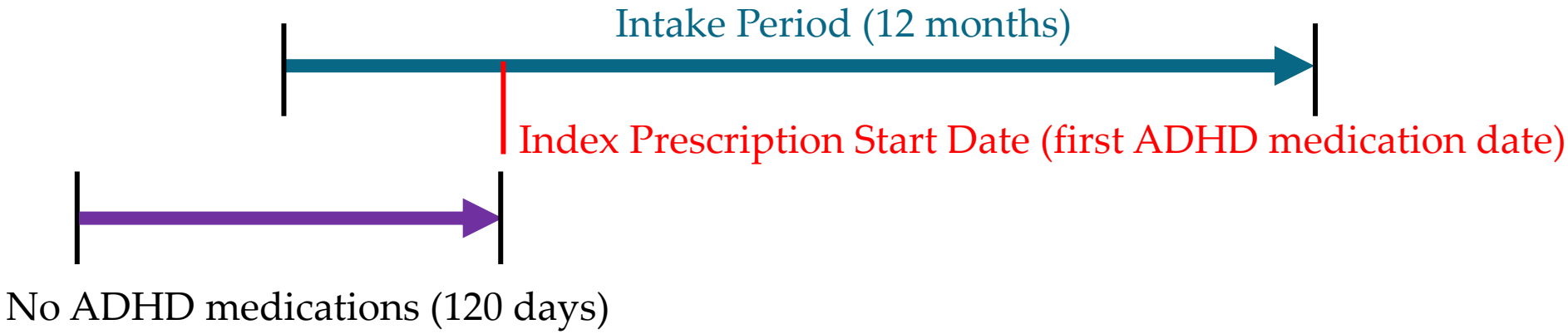
- When the Measurement Period has the standard 12-month length, the Intake Period is 10 months before the **start** of the Measurement Period to 10 months before the **end** of the Measurement Period



Other Definitions

Index Prescription Start Date (IPSD)

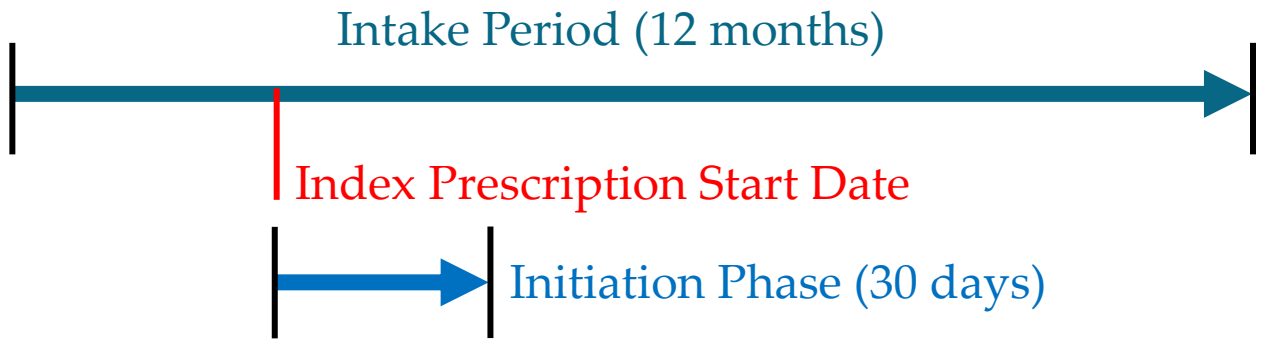
- First new ADHD medication date during the Intake Period
- A "new" prescription is defined as having no other ADHD medication prescription or action in the 120 days prior
- The 120 days prior period can encompass dates before the Intake Period



Two Numerators for Two Quality Measures

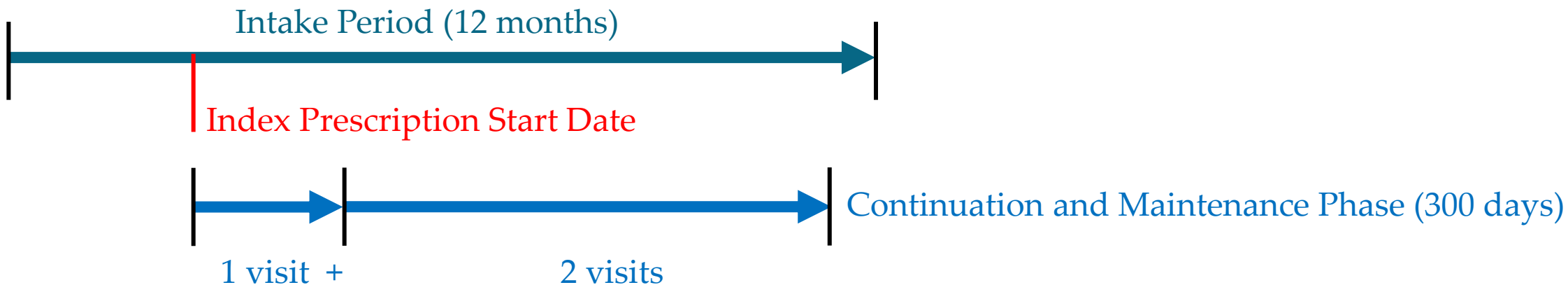
Numerator 1—Initiation Phase

- Had a follow-up visit with a practitioner with prescribing authority during the Initiation Phase



Two Numerators for Two Quality Measures

- Numerator 2—Continuation and Maintenance Phase
- A follow-up visit during the Initiation Phase (Numerator 1, during the first 30 days after the IPSD) **and** two follow-up visits with any practitioner during the 31–300 days after the IPSD



Practitioner Definitions

Initiation Phase: UDS provider with prescribing authority. Relevant Staff member types:

- Family Physicians
- General Practitioners
- Internists
- Obstetrician/Gynecologists
- Pediatricians
- Other Specialty Physicians
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Psychiatrists

Practitioner Definitions

Continuation and Maintenance Phase: UDS provider (medical or behavioral health). Staff member types:

- Same as Initiation Phase (see last slide)

PLUS, BH providers normally without prescribing authority:

- Licensed Clinical Psychologists
- Licensed Clinical Social Workers
- Other Licensed Mental Health Providers

New Transformer/Data Element: ADHD Medications

- Different than other standard medication Transformers/Data Elements because it must show individual medication dates (not just a start date and an end date)
- Also must show how many days the medication was prescribed. Important because the Continuation and Maintenance Phase must have 210 medication treatment days of an ADHD medication during the 300-day period.
- In other words, we need to know that the patient is continuing with the medication in the Continuation and Maintenance Phase

Other Notes

- There is not a separate Transformer/Data Element pair for Narcolepsy
- The Quality Measure extracts potential Narcolepsy diagnosis codes directly from the Problem List using the HEDIS Value Set

hedis_value_set_codes.value_set_name = 'Narcolepsy'

Unhealthy Alcohol Use Screening and Follow-Up (ASF)

Follows HEDIS Definition

Basic Premise

- Similar approach as some of the UDS Preventive Care and Screening measures (for example, tobacco screening/follow-up or body mass screening/follow-up)
- All denominator patients need to be screened for unhealthy alcohol use annually
- Patients who screen positive need to have follow-up within 60 days

Completely New Measure

- Therefore, new Transformers and Data Elements are required
- The RCHC ECDS Quality Measure Instruction Document has sample SQL code
- See the July 2022 Data Workgroup presentation for more detail

New Transformers/Data Elements for Alcohol Screening

Data Element names:

- AUDIT C Screens
- AUDIT Screens
- Single Question Alcohol Use Screens

Note that the single question screen must adhere to specific language or be approved by Partnership. The Partnership specifications document has additional detail in the Additional Background Information section for the measure.

New Transformer/Data Element for Alcohol Counseling

- Data Element name: Alcohol Counseling Or Other Followups
- Specifically for alcohol counseling or other follow-ups entered into structured data. The July 2022 Data Workgroup presentation talked about using an RCHC Validation Report (eCW health centers) to identify structured data items
- Alcohol counseling events entered by CPT code or ICD-9 code are gathered directly by the Quality Measure using HEDIS Value Sets. Do not add these to this Data Element

New Transformers/Data Elements for Exclusions

Data Element names:

- Alcohol Use Disorder Cases
- Dementia Cases

Use the HEDIS Value Sets to define these cases

- hedis_value_set_codes.value_set_name = 'Alcohol Use Disorder'
- hedis_value_set_codes.value_set_name = 'Dementia'

A Note on Alcohol Follow-up by ICD-9 Code

- The HEDIS Value Set* contains the diagnosis code “Z71.89”
- This code is a general code for counseling of any kind
- Therefore, for this measure, it MUST be paired with a description with “alcohol” in it

** hedis_value_set_codes.value_set_name = 'Alcohol Counseling or Other Follow Up Care'*

Code Feedback

- Please send Ben (bfouts@rchc.net) any feedback on the SQL contained in the RCHC QIP ECDS Quality Measure Document
- The Quality Measures on the RCHC Aggregate will always be the most current version of the code
- Enhancements to the SQL code will be announced on the Slack channel or in future Data Workgroup sessions

Questions?