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

**January 6, 2020 Meeting**

Version 2, By Ben Fouts MPH, RCHC Data Analyst

1. **Using Value Sets to Define Medications for the Quality Measures**

Report: All UDS measures that require medications (and hopefully also QIP Measures in the future)

Issue: Validation of the new medications Transformer (relevant\_medications).

Description: A new Transformer for medications has been added to Relevant with the intention of allowing medications to be identified by their association with the eCQM Value Sets. As previously discussed in this Committee, published Value Sets use the RXNORM standard but the medication compendium in eCW and NextGen uses the NDC standard. Relevant created this Transformer to bridge the two standards using a crosswalk.

Health centers can examine which medications in their system are associated with the Value Sets by using the new RCHC validation report named “List All Medications and Rx Groups.[[1]](#footnote-1)” This report lists all medications with an action in the measurement period. One medication (having a unique ItemID) is displayed on one row and there are columns for the Rx Group(s) and the Value Set(s).

The health center should run the report (suggested measurement period start date = 1/1/2018 to see all “recent” medications) and export the results to Excel. Use the Filter function in Excel to filter and count medications in each of the UDS categories for medications. You can filter the Rx Group(s) and Value Set(s) columns separately and together.

Additional Information: Beginning on the next page are examples of a medication data summary from two health centers. What we are interested in is the extent that the medications in the Rx Groups overlap the medications in the Value Sets. Adopting this approach assumes that your health center has maintained the medication lists in the Rx Group. Both of the health centers in the example have been updating their Rx Groups.

In these examples, you can see that only about 74% to 80% of the medications in the five major groups are common between the Value Set and the Rx Group. More medications are identified by the Value Set method. Around 20% to 22% of medications identified by the Value Sets were not part of the corresponding Rx Group. Conversely, 13% to 16% of the medications in the Rx Group were not in the Value Set.

It is recommended that each health center use the RCHC validation report to make a similar table for their own medication groups. Look at the medications not common between the two sets and determine if these legitimately should be in the measure. Furthermore, if you are going to continue using the Rx Groups for your 2019 Quality Measures, you can see which medications are missing from your Rx Groups and add them in.

Ben Fouts has made some recommendations to Relevant during his validation of the Transformer, so there might be a new version available soon. When are we as a group going to implement the switch to using the Value Sets to identify medications for the Quality Measures?

*Example of Medication Data from Petaluma Health Center*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| UDS measure QMs | UDS value set names | Total medications | | Overlap between the two sets | Value Set but not Rx Group | Rx Group but not Value Set |
| Value Sets | RX Groups |
| Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet | Anticoagulant Medications | 24 | 22 | 21 | 12.5% | 4.5% |
| Aspirin and Other Antiplatelets | 62 | 61 | 51 | 17.7% | 16.4% |
| Screening for Depression and Follow-Up Plan | Depression medications | 117 | 115 | 91 | 22.2% | 20.9% |
| Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | Statin therapy | 25 | 25 | 25 | 0.0% | 0.0% |
| Tobacco Use Screening and Cessation Intervention | Tobacco Use Cessation Pharmacotherapy | 68 | 45 | 44 | 35.3% | 2.2% |
|  |  | 296 | 268 | 73.7% | 21.6% | 13.4% |

*Example of Medication Data from Santa Rosa Community Health*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| UDS measure QMs | UDS value set names | Total medications | | Overlap between the two sets | Value Set but not Rx Group | Rx Group but not Value Set |
| Value Sets | RX Groups |
| Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet | Anticoagulant Medications | 24 | 16 | 16 | 33.3% | 0.0% |
| Aspirin and Other Antiplatelets | 84 | 89 | 75 | 10.7% | 15.7% |
| Screening for Depression and Follow-Up Plan | Depression medications | 129 | 136 | 107 | 17.1% | 21.3% |
| Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | Statin therapy | 31 | 39 | 31 | 0.0% | 20.5% |
| Tobacco Use Screening and Cessation Intervention | Tobacco Use Cessation Pharmacotherapy | 85 | 54 | 52 | 38.8% | 3.7% |
|  |  | 353 | 334 | 79.6% | 20.4% | 15.9% |

1. **Estimating the Impact of the Change to the Quality Measure for Blood Pressure Control Among Patients With Hypertension**

Report: Controlling High Blood Pressure

Issue: The 2020 eCQM definition has changed. This change will impact both the denominator and the numerator of the measure.

Description: The 2019 eCQM (165v7) states that the initial population for the measure consists of “Patients 18-85 years of age who had a diagnosis of essential hypertension *within the first six months of the measurement period or any time prior to the measurement period*” (emphasis added). This is also reflected in the 2019 UDS Manual (see page 99).

However, the 2020 eCQM (165v8) states that the initial population for the measure consists of “Patients 18-85 years of age who had a visit and diagnosis of essential hypertension *overlapping the measurement period*” (emphasis added). There is no “6-month” criterion in the 2020 version of the measure.

The 2019 QIP hypertension measure, which is based on the 2019 HEDIS definition, does not have this 6-month criterion. So, this measure has already switched to the new approach.

Additional Information: The table below displays how the new definition would impact the measure at the RCHC health centers. Essentially, it would add newly diagnosed patients to the denominator who tend to have high blood pressure. Therefore, the denominator would increase by 9.4% overall and the numerator percentage would decrease by 1.2%. There is some variability among the health centers.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Health Center** | **Current QM** | | **New Definition** | | |
| **Denominator** | **Numerator** | **New Patients** | **Difference from Old Denominator** | **Impact to New Numerator** |
| Santa Rosa | 5,976 | 65.1% | 547 | 9.2% | -1.4% |
| Petaluma | 4,067 | 77.6% | 389 | 9.6% | -0.9% |
| Ole | 4,738 | 60.7% | 478 | 10.1% | -0.7% |
| CommiCare | 2,512 | 71.4% | 277 | 11.0% | -1.3% |
| Winters | 345 | 65.5% | 23 | 6.7% | -1.1% |
| Coastal | 623 | 67.6% | 45 | 7.2% | -1.1% |
| Alex Valley | 565 | 82.7% | 38 | 6.7% | -0.1% |
| Ritter | 206 | 58.7% | 35 | 17.0% | -1.5% |
| Marin City | 327 | 67.3% | 59 | 18.0% | -2.8% |
| Marin Community | 4,078 | 72.6% | 367 | 9.0% | -1.7% |
| Sonoma Valley | 1,274 | 71.1% | 80 | 6.3% | -0.4% |
| SCHIP | 726 | 60.3% | 51 | 7.0% | -0.9% |
| All RCHC | 25,437 | 68.7% | 2,389 | 9.4% | -1.2% |

1. **Patient Insurance**

Report: PHASE Diabetes HbA1c Good Control (≤9%), but idea can be spread to other reports

Issue: A standard definition for a patient’s medical insurance

Description: The 2020 PHASE Quality Measure for blood sugar control among patients with diabetes focuses on patients without insurance. There may be other measures that would be interesting to examine for uninsured populations (e.g., to study health disparities) or to compare patients belonging to the major UDS insurance categories (i.e., uninsured, private insurance, Medicaid, Medicare, Dual Eligible, etc.).

All of the health centers have some method to define a patient’s insurance status, but if we are going to aggregate the data in the RCHC instance of Relevant, we should agree on a standard approach. This involves two steps: agreeing on a definition and then ensuring that the code in Relevant follows this definition.

One definition for insurance status comes from the UDS Report. Page 36 of the 2019 UDS Manual defines principal insurance as follows: “Report the primary medical insurance patients had at the time of their last visit regardless of whether that insurance was billed or paid for any or all of the visit services. (Do not report other forms of insurance such as dental, mental health, or vision coverage).”

First of all, note that this definition is looking at an insurance from a visit, not just the insurance that is the current Primary Insurance in the patient record (for example, in the “Hub” in eCW). This is good because the Primary Insurance can change day-to-day and sometimes the one that is there may never have been billed.

Second, note that this definition is looking for medical insurance and excluding other insurance for non-medical services. This is also important because if we are looking at clinical (medical) Quality Measures, we want to compare the type of medical insurance patients have.

Here are some examples of approaches to determining patient insurance.

1. Take the primary insurance on their record (i.e., from the Hub)
2. Take the last insurance billed for any UDS medical visit. If there was not a medical visit, take the last insurance for any billed visit in the UDS universe. If there was not a billed visit, take the last insurance for any visit in the UDS universe.
3. Prioritize visits based on program. First priority is medical visits. Take the last insurance\* for any medical visit. If there was not a medical visit, take the last insurance for any dental visit. If there was not a medical visit, take the last insurance for any behavioral health visit. If the patient did not have a visit, then the current primary insurance (i.e., from the hub) is used.

\* Insurance: priority is for the last visit where an insurance paid for the visit, and if there is not one of those, take the last insurance that billed for the visit

Whatever insurance is determined to be the patient’s insurance is then categorized based on your health center’s insurance groups. Therefore, if the insurance is purely a dental insurance or purely a behavioral health insurance, it would be classified as uninsured.

Additional Information

Check how UDS insurance is assigned in Relevant at your health center. There are two parts to this.

*Part 1: Assign an insurance to a patient*

Importer: Insurance Enrollments

This Importer will display an insurance (column payer\_id) for each patient (column patient\_id) by calendar year (column year) and whether the patient is dual eligible (column medicare\_dually\_eligible). There may or may not be an associated Transformer (for example, relevant\_insurance\_enrollments).

Note that for the purposes of the PHASE measure (and other applications), we would have to figure out a way to bypass the calendar year requirement (because the measure would need to be run at various times during the year, not at a set end-point at the end of the year).

*Part 2: Place insurance names into UDS categories*

Importer: Payers

Based on the Transformer relevant\_payers

Displays insurance name in each row, along with the insurance group (column payer\_group\_id) and TRUE/FALSE columns for each major UDS insurance category (private, Medicaid, chip, medicare, and uninsured). The customized Transformer assigns a UDS insurance category depending on the conditions at the health center. For example, most eCW health centers use the internal Insurance Group (most common) or insurance name (for rare exceptions). Most NextGen health centers use the financial class of the insurance.

1. See the e-mail from Colleen Petersen on December 4, 2019 with the subject line “New Set of Relevant Validation Reports (eCW Version).” The NextGen versions will be released later in December 2019. [↑](#footnote-ref-1)