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

November 5, 2018 Meeting

Version 1, By Ben Fouts MPH, RCHC Data Analyst

1. **Diagnosis Codes From Telephone Encounters**

Reports: Controlling High Blood Pressure (essential hypertension diagnosis before 6 months), Adult BMI Screening and Follow-up (pregnancy observations), Child Weight Assessment and Counseling (nutrition and physical ed counseling), QIP Diabetes Blood Sugar Control (time-limited exclusions), Depression Screening and Follow-up Plan (depression diagnosis date), and others that use code codes from Assessments.

Issue: Are all Assessments created equally? Can we rely on the diagnosis codes that appear on all kinds of Assessments as a description of reality, or are there some Assessments taken at some times that might not be as reliable as others?

Description: One health center mentioned that Assessments during telephone encounters might not have reliable diagnosis codes in the same way as a face-to-face encounter where the provider clinically evaluates the patient. Is this true at other health centers? Are there other visit types that should be excluded?

Relevant reports currently only consider encounters that have the CHK (“checked-out”) status, but consider Assessments for all visit types. BridgeIT reports consider all Assessments without regard to status or visit type. Should there be code added to exclude any specific visit types? Alternately, the reports could only consider, for example, Assessments done at UDS Visits (using the definition defined by the health center already).

1. **Standardizing Relevant Expressions**

Report: All Relevant reports (but also effects systems with their own custom reports)

Issue: Should common design elements be incorporated into all reports in order to standardize them, or should different reports have different design elements depending on author preference? Is there any advantage to using a particular design approach for all reports that use particular elements?

Description: Many of the Quality Measure reports (and also many of the custom reports), pull data from particular areas of the health record. Here are some examples:

1. Diagnosis codes from the Problem List
2. Diagnosis codes from Assessments
3. Results from specific labs
4. Taking particular medications
5. Administration of specific vaccines

Different reports will pull different combinations of these areas, and even differ in the specific items within the area. For example, the diabetes blood sugar control measure and the hypertension blood pressure control measure both identify patients in the denominator, in part, by codes on the Problem List. Given that there is flexibility with how the SQL code can be written, should there be one standard code that should be used, differing only in the particular codes that define the different populations?

Additional Information:

Example for the Diabetes Blood Sugar Control measure. There are 304 diagnosis codes (ICD-10) that define “diabetes.” These codes come from a Value Set definition that is updated every year. There are at least two major ways that the code set can be managed:

1. Format a file of all Value Set diagnosis codes for all main conditions that can be uploaded to Relevant every year. Reports that rely on these codes can be linked to the file. The file would identify diabetes diagnosis codes and be used to pull the patients with the same codes.
2. Program code in SQL that directly queries for the codes in the Value Set. When the codes change, go in and change the SQL.

To change to a standardized approach,

Pro: Less work year-to-year. Reports automatically updated when the new Value Set uploaded. No need to manually go through codes in SQL to ensure that they are correct. A separate report can be designed to display the codes if someone wants to see them. Standardizing the method makes it easier to understand how data is pulled (you just have to understand one approach for each area) whereas if it was not standard, you would have to investigate and validate each report to ensure it is correct. A standard method also provides a predictable approach to the common design elements and can help report authors at the health centers by providing groups of proven SQL codes that can be modified as necessary, instead of having authors re-invent the wheel or try novel approaches to common problems.

Con: More work up front because reports are not all designed in this way. Reports “seem” to be working well now, so why mess with it? Give as much flexibility to the report authors as possible and don’t impose design constraints. Someone who reads SQL can see up front what all of the codes are. Changes to the Value Set each year are generally small.