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

November 5, 2019 Meeting

Version 1, By Ben Fouts MPH, RCHC Data Analyst

1. **Follow-up to Issue From last Time: Definition of Patients With Persistent Asthma**

Reports: UDS and QIP reports that identify patients with persistent asthma

Issue: What is the best methodology to classify patients with both an active intermittent asthma diagnosis code and an active persistent asthma diagnosis code on the Problem List.

Description: This issue was described during the September 9th, 2019 Data Standards and Integrity Committee meeting and health centers were asked to investigate the issue further and bring findings and conclusions back to this meeting.

A sizeable number of patients among all RCHC health centers using Relevant have both active persistent and intermittent asthma diagnosis codes on the patient’s Problem List (for lack of a better term, these will be referred to as patients with “dual diagnosis” in this section). The Relevant Transformer “asthma\_cases” classifies these patients into one of the two groups based on the date of the last diagnosis added to the Problem List. However, based on this methodology, approximately the same proportion of dual-diagnosis patients considered as having intermittent asthma are being treated with medications as if they have persistent asthma as the actual denominator for the measure.

If these “false negatives” are added to the denominator, the overall number of patients with persistent asthma could rise by 11.8% among all RCHC health centers (range 0% to 48.6%). By adding them, the numerator would change by zero percent among all RCHC health centers (range -3.5% to 4.4%).

Additional Information: There are at least two options to consider, although health centers are welcome to add others:

1. Make no changes to the Transformer. Therefore, patient diagnosis (intermittent versus persistent) based on the last diagnosis added to the Problem List, by date
2. Change the Transformer so that a persistent diagnosis, if present on the Problem List, takes priority and is sufficient to identify a patient as having persistent asthma

There will be a new Relevant validation report released soon that identifies all of these dual-diagnosis patients so health centers can identify them and potentially inactivate one of the codes depending on clinical evidence. Regardless of how the Relevant Transformer handles these patients, for workflow, clinical treatment, and documentation matters, these patients should really be classified in one way or another on their Problem List.

1. **Anticipated Changes to the 2020 UDS Clinical Measures**

Reports: UDS Quality Measure Set

Issue: References to the new, updated, and retired Clinical Quality Measures were released in the Program Assistance Letter (PAL) dated July 22, 2019 and titled “Proposed Uniform Data System Changes for Calendar Year 2020.” The official 2020 UDS Instruction Manual has not yet been released, so the information described below may change.

Description: The changes to the Quality Measures outlined in the PAL are as follows:

1. 2 retired measures
2. 7 proposed new measures
3. 12 measures from 2019 will be carried over into 2020. Ten of these have updated versions of the eCQM (measure definition technical specification).

Additional Information:

Below is more detail on the anticipated changes. Again, these are proposed changes only.

*Retired measures*

* Use of Appropriate Medications for Asthma
* Dental Sealants for Children between 6-9 Years

*Proposed new measures*

| Measure Name | Brief Definition | | |
| --- | --- | --- | --- |
| Denominator | Numerator | Exclusion |
| Measures with same definitions as current or former QIP measures | | | |
| Diabetes: Eye Exam (CMS131v8) | Number of patients between 18 and 75 years of age with a diagnosed with diabetes and a medical visit in the measurement period. | Number of denominator patients with a screening for diabetic retinal disease. This includes:  • A retinal or dilated eye exam by an eye care professional in the past year  • A negative result on a retinal or dilated eye exam by an eye care professional in the past two years. | Hospice care, advanced illness or frailty |
| Diabetes: Foot Exam (CMS123v7) | Number of patients between 18 and 75 years of age with a diagnosed with diabetes and a medical visit in the measurement period. | Number of denominator patients with a foot exam in the measurement period. This includes a visual inspection, sensory exam with mono filament and a pulse exam. | Hospice care, advanced illness or frailty |
| Diabetes: Medical Attention for Nephropathy (CMS134v8) | Number of patients between 18 and 75 years of age with a diagnosed with diabetes and a medical visit in the measurement period. | Number of denominator patients with screening for nephropathy or evidence of nephropathy during the measurement period. This includes particular labs, medications and diagnosis codes. | Hospice care, advanced illness or frailty |
| Breast Cancer Screening (CMS125v8) | Number of female patients between 50 and 74 years of age and a medical visit in the measurement period. | Number of denominator patients with one or more mammograms during the 27 months prior to the end of the measurement period. | Complete bilateral mastectomy  Hospice care, advanced illness or frailty |
| Other measures | | | |
| Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists (CMS74v9) | Number of patients 20 years of age and younger with a medical visit in the measurement period. | Number of denominator patients who received a fluoride varnish application during the measurement period. | Hospice care |
| Depression remission at twelve months (CMS159v8) | Number of patients 12 years of age and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during the index event.  The index evens must occur between 2 months and 14 months before the start of the measurement period. | Number of denominator patients who achieved remission at twelve months after the index event (+/- 60 days) as demonstrated by a PHQ-9 score of less than five. | Diagnosis of bipolar disorder, personality disorder, pervasive developmental disorder, schizophrenia or psychotic disorder  Hospice or palliative care services |
| HIV Screening (CMS349V2) | Number of patients 15 to 65 years of age and younger with a medical visit in the measurement period. | Number of denominator patients with an HIV test performed on or after their 15th birthday and before their 66th birthday. | Diagnosis of HIV prior to the start of the measurement period |

*Measures carried over from 2019. Major changes noted.*

* Childhood Immunization Status. Changed HIB vaccine from three doses to three doses or four doses, depending on the current guidelines of the manufacturer of the vaccine. There are different Value Sets for 3-dose and 4-dose HIB vaccines.
* Cervical Cancer Screening. No changes.
* Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents. No changes.
* Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan. Change to exclusion for hospice care (see note below).
* Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. No changes.
* Statin Therapy for the Prevention and Treatment of Cardiovascular Disease. Change to exclusion for hospice care (see note below).
* Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet. No changes.
* Colorectal Cancer Screening. Change to exclusion for frailty (see note below).
* HIV Linkage to Care. Change to the follow-up treatment timeline from 90 days after initial diagnosis to 30 days.
* Preventive Care and Screening: Screening for Depression and Follow-Up Plan. The change might not apply to most of our practices. In (rare) cases where a screening (like a PHQ-2) is done outside of a visit with a medical or behavioral health provider, a positive screen must have follow-up within 14 days during an encounter with a medical or behavioral health provider.
* Controlling High Blood Pressure. Change so that a patient with a diagnosis of essential hypertension does not need to be diagnosed prior to 6 months before the beginning of the measurement period. Also change to exclusion for frailty (see note below).
* Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%). Change to exclusion for frailty (see note below).

Note on exclusion for hospice care: language changed from “patients receiving palliative care” to “Patients receiving palliative or hospice care”

Note on exclusion for frailty: these are patients with advanced illness and frailty (i.e., use of frailty devices, dementia medications, diagnosis of advanced illness, etc.) or in long-term care.

1. **Preparation of New or Updated Standard Quality Measures in the Relevant Software by the Health Center**

Reports: Quality Measures Developed by the Relevant Support Team or the RCHC Data Team

Issue: What is a reasonable timeline for health centers to prepare new or updated Quality Measures (QM) so they can be utilized by the health center and so data can feed into the RCHC aggregate instance?

Description: The complete 2019 UDS and QIP Quality Measure Sets will soon be released by the Relevant Support Team along with instructions on how to prepare and validate the new QM reports. This preparation is typically done by someone at the health center knowledgeable with SQL coding and familiar with the unique and preferred way that groups of data elements are queried in Relevant (e.g., labs, medications, etc.). New QM reports may require new or modified Transformers, depending on the measure requirements. Code from all related Transformers, Imports and the new version of the QM report itself must be examined and validated before the QM can be used and trusted.

The Data Standards and Integrity Committee should discuss if it is reasonable to apply a deadline for this preparation and validation work, and how much time might typically be needed for it. Obviously, it is in the interest of the health center to deploy the current Measure Sets as they become available (e.g., 2019 instead of 2018 now). Because the same Measure Sets are displayed in the RCHC Aggregate Instance of Relevant, it is also important that there is a recognized point-in-time where we can be sure that all the data from all the health centers that flows into the aggregate is accurate and valid for the new Measure Sets.

Additional Information: Health Centers should consider their own capacity and internal routines to achieve the goal of new QM preparation and validation in a timely manner.

* Who does the work and how are they accountable?
* How will a supervisor know that the validation is complete?
* What documentation exists to record internal best practices for pulling specific kinds of data and the results of a validation effort?
* How should progress on validation be communicated to RCHC?
* How should RCHC communicate to the health centers that the aggregate data is valid for particular measures?

1. **Potential Patient Portal Measures**

Reports: No reports exist yet.

Issue: Is there an interest in developing any patient portal measures that could be used for internal quality assurance purposes at the health centers and possibly aggregated in the RCHC instance?

Description: There are no standard patient portal measures in the UDS or QIP Quality Measure Report Sets. The closest official measures most health centers have already seen come from Meaningful Use.

The Meaningful Use definitions focus on two aspects of electronic access. The first is an action by the health center to provide access to online health information by signing patients up for portal use. The second is an action by patients to log-in and use the portal.

*For example, 2018 Medicaid Meaningful Use Stage 2 Objective 8: Patient Electronic Access*

Measure 1 Requirements: Eligible professionals must provide patients with the ability to view online, download, and transmit their health information. Specifically, more than 50 percent of all unique patients seen by the eligible professional during the EHR reporting period must be provided timely online access to their health information subject to the eligible professional’s discretion to withhold certain information

Measure 2 Requirements: Eligible professionals are required to provide patients with an electronic copy of their health information (diagnostic test results, problem lists, medication lists, and

allergies) upon request. Specifically, 5 percent of all unique patients seen by the eligible professional during the EHR reporting period must have used the capability to view online, download or transmit to a third party their health information.

Additional Information: A Relevant report can be developed for the two Meaningful Use measures described above using data currently available in the software. Other potential measures depend on the availability of data generated by the health center and if it is accessible in Relevant.

Below is a list of other potential measures. If any are of interest to the group, more detail can be added at a later date (i.e., denominator and numerator definitions, age limitations or groupings, etc.)

1. Percentage of patients seen in the Measurement Period not currently enabled for the portal who are given new access (i.e., portal switched on).
2. Percentage of patients given new access to the portal in the Measurement Period who accessed the portal at least once.
3. Percentage of all web-enabled patients seen in the Measurement Period who accessed the portal at least once.
4. Percentage of web-enabled patients seen in the Measurement Period who accessed the portal and navigated within the portal (more detail can be given, if that exists in Relevant, for example, which sections of the portal were more commonly accessed).
5. Percentage of labs or images performed in the Measurement Period for web-enabled patients that were published to the portal
6. Percentage of web-enabled patients with a lab or image published to the portal in the Measurement Period who actually accessed the lab or image on the portal.