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

April 16, 2018 Meeting

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Part 1: Follow-up on Issues From March Meeting

**Follow-up Issue #2: Standardized Text for Cancer Screening Exclusions from Surgical and Medical Histories**

Reports: Cervical Cancer, Breast Cancer and Colorectal Cancer Screening

Additional Information: The proposal is to make the exclusion definitions more precise in order to minimize the number of patients incorrectly included (or not included) in the measure exclusion.

To identify exclusions, the data report would search for any of the following:

| Measure | Exclusion Description | Diagnosis Code on Problem List | Text in Surgical or Medical History |
| --- | --- | --- | --- |
| Cervical Cancer Screening | Women who had a hysterectomy with no residual cervix | * Q51.5: Agenesis and aplasia of cervix
* Z90.710: Acquired absence of both cervix and uterus
* Z90.712: Acquired absence of cervix with remaining uterus
 | * Complete hysterectomy
* Radical hysterectomy
* Total hysterectomy (but not ‘subtotal’)
 |
| Breast Cancer Screening | Bilateral mastectomy or evidence of a right and a left unilateral mastectomy | * Z90.13: Acquired absence of bilateral breasts and nipples

Or both of:* Z90.11: Acquired absence of right breast and nipple
* Z90.12: Acquired absence of left breast and nipple
 | * Bilateral mastectomy

Or two of the following with different surgical dates:* Unilateral mastectomy
 |
| Colorectal Cancer Screening | Total colectomy or colorectal cancer | * C18.0: Malignant neoplasm of cecum
* C18.1: Malignant neoplasm of appendix
* C18.2: Malignant neoplasm of ascending colon
* C18.3: Malignant neoplasm of hepatic flexure
* C18.4: Malignant neoplasm of transverse colon
* C18.5: Malignant neoplasm of splenic flexure
* C18.6: Malignant neoplasm of descending colon
* C18.7: Malignant neoplasm of sigmoid colon
* C18.8: Malignant neoplasm of overlapping sites of colon
* C18.9: Malignant neoplasm of colon, unspecified
* C19: Malignant neoplasm of rectosigmoid junction
* C20: Malignant neoplasm of rectum
* C21.2: Malignant neoplasm of cloacogenic zone
* C21.8: Malignant neoplasm of overlapping sites of rectum,
* C78.5: Secondary malignant neoplasm of large intestine an
* C7A.021: Malignant carcinoid tumor of the cecum
* C7A.022: Malignant carcinoid tumor of the ascending colon
* C7A.023: Malignant carcinoid tumor of the transverse colon
* C7A.024: Malignant carcinoid tumor of the descending colon
* C7A.025: Malignant carcinoid tumor of the sigmoid colon
* C7A.026: Malignant carcinoid tumor of the rectum
* Z85.038 : Personal history of other malignant neoplasm of la
* Z85.048: Personal history of other malignant neoplasm of re
 | * Colorectal cancer
* Malignant neoplasm of the
* colon
* cecum
* appendix
* hepatic flexure
* rectosigmoid junction
* rectum
* anus
* anal canal
* cloacogenic zone
* large intestine
* Total colectomy (but not partial, hemi, or sub)
 |

To identify patients with general cancer terms, the validation reports will display the following patients:

| Measure | Text in Surgical or Medical History |
| --- | --- |
| Cervical Cancer Screening | Hysterectomy (by itself) |
| Breast Cancer Screening | Mastectomy (by itself) |
| Colorectal Cancer Screening | Colectomy (by itself) |

This approach assumes that a patient who meets the normal denominator criteria should be screened unless there is enough evidence in the medical record to exclude them. When a provider sees a denominator patient, alerts in eCW or Relevant Visit Planning may prompt the provider to initiate the cancer screening process. If the provider determines that the patient should indeed be excluded from this screening, the correct diagnosis code should then be placed on the Problem List or text into Surgical History so the alert will no longer be active. This action will also cause the data report to exclude the patient.

**Follow-up Issue #3:** **Standardized Text for Cardiovascular Surgery** **from Surgical and Medical Histories**

Reports: Ischemic Vascular Disease (IVD) and Use of Aspirin or Another Antiplatelet; Coronary Artery Disease (CAD) and Lipid Therapy

Additional Information: Two reports use some overlapping kinds of cardiovascular events to identify patients in the denominator. Some of these events are *experiences* (such as a heart attack) and some are *surgical procedures* (such as a coronary artery bypass).

In the meeting last month, it was suggested that experiences be identified with diagnosis codes on the Problem List and surgical procedures be identified with text in Surgical history. On the next page is a table containing the proposed diagnosis codes and text.

|  |  |  |  |
| --- | --- | --- | --- |
| Measure | Denominator Description (Event Portion) | Diagnosis Code on Problem List  | Text in Surgical History |
| Ischemic Vascular Disease | Acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) | * I21.01: ST elevation (STEMI) myocardial infarction
* I21.02: ST elevation (STEMI) myocardial infarction
* I21.09: ST elevation (STEMI) myocardial infarction
* I21.11: ST elevation (STEMI) myocardial infarction
* I21.19: ST elevation (STEMI) myocardial infarction
* I21.21: ST elevation (STEMI) myocardial infarction
* I21.29: ST elevation (STEMI) myocardial infarction
* I21.3: ST elevation (STEMI) myocardial infarction of unsp
* I21.4: Non-ST elevation (NSTEMI) myocardial infarction
* I21.9: Acute myocardial infarction, unspecified
* I21.A1: Myocardial infarction type 2
* I21.A9: Other myocardial infarction type
* I22.0: Subsequent ST elevation (STEMI) myocardial infarct
* I22.1: Subsequent ST elevation (STEMI) myocardial infarct
* I22.2: Subsequent non-ST elevation (NSTEMI) myocardial in
* I22.8: Subsequent ST elevation (STEMI) myocardial infarct
* I22.9: Subsequent ST elevation (STEMI) myocardial infarct
* I23.0: Hemopericardium as current complication following
* I23.1: Atrial septal defect as current complication
* I23.2: Ventricular septal defect as current complication
* I23.3: Rupture of cardiac wall without hemopericardium as
* I23.4: Rupture of chordae tendineae as current complic
* I23.5: Rupture of papillary muscle as current complic
* I23.6: Thrombosis of atrium, auricular appendage, and ven
* I23.7: Postinfarction angina
* I23.8: Other current complications following acute myocar
* I25.2: Old myocardial infarction
 | * Percutaneous coronary intervention
* PCI
* Stent
* Coronary artery bypass
* Coronary angioplasty
* CABG
 |
| Coronary Artery Disease | Myocardial infarction (MI) or had cardiac surgery CABG or PTCA | Same as above for IVD | * Coronary artery bypass
* Coronary angioplasty
* CABG
* Percutaneous transluminal coronary angioplasty
* PTCA
 |

Part 2: Other Issues to Consider

**(From last meeting, not covered because of time) Issue #5: Continue Holding a High Meaningful Use Standard for Lab Record Completion in Structured Data**

Reports: All reports that use lab data

Description: Some measures require the completion of a particular lab. The BridgeIT reports rely on the eCW definition of a completed lab in structured data that complies with Meaningful use criteria. These are:

1. The result date has been entered into the Lab Results window
2. The Received box has been checked on the Lab Results window
3. At least one value has been entered in the yellow row on the Lab Results window (the exception is the cervical cancer screening lab, which allows for a result in the Result drop-down box)

There are validation reports in BridgeIT that display labs missing any of these components. If a lab was ordered but not done, the lab should be cancelled or deleted.

Pro: This approach is superior because it ensures that important lab dates and values are in fields that can be queried. This is essential for the reports to make the appropriate calculations, and also for eCW Alerts and Relevant Care Gaps to work. Furthermore, this approach ensures that results that need to trigger immediate action (for example, a positive cervical cancer screening result) are displayed in the appropriate fields of eCW and not buried in attachments or documents.

This approach should be continued in Relevant and “sort cuts” (like allowing non-structured results such as the existence of attachments) should not be programmed.

Con: Having a high standard means that proper data entry procedures must be taught and then monitored. This takes time. Bringing in grey and pink paperclips, or looking at billing data for labs, increases the numerator when not all the results are in structured data.

**(New) Issue #5: Transgender Patients and Breast Cancer Screening**

Reports: Breast Cancer Screening

Description: Currently, the BridgeIT breast cancer screening report includes patients who are marked as Female in the Sex field of Patient Demographics in eCW. The cervical cancer screening report additionally considers the transgender field in Structured Demographics or Social History. Should patients marked “Transgender: Male/Female-to-Male” in the transgender field also be added to the BridgeIT report?

Pro: Considerable work is now being done to appropriately identify transgender patients. The Sex field on the Patient Demographics screen is no longer precise enough to identify patients who need this kind of screening. The assumption is that all patients marked “Transgender: Male/Female-to-Male” in the transgender field will need breast cancer screening and cervical cancer screening (no matter the entry into the Sex field).

Con: Is this appropriate, clinically, for all patients including those who are undergoing hormone therapy or have completed sexual reassignment?