Reporting the 2020 Performance Improvement Program (PIP) Clinical Measures [Version 10]

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Introduction

The purpose of this document is to describe how to obtain valid measurement results from the Relevant reports in order to provide results on the four 2020 Performance Improvement Program (PIP) clinical measures.

Detailed information on the Performance Improvement Program, including a rational for and definition of the measures, exists in the document "Redwood Community Health Coalition, Performance Improvement Program, Program Year 2020-Revised" available directly from RCHC. Each PIP clinical measure has a unique Relevant Quality Measure that can be used to monitor progress towards the stated goals and report data at the requested times.

These instructions were written for staff at RCHC-affiliated clinics who are familiar with the basic functions Relevant. All reports should be run with a measurement period of one year (12 months) ending on the last day of the quarter specified by the schedule (see 2020 program documentation). This measurement period length, reported every quarter, is commonly called a "rolling" time frame. Basically, it is asking, every quarter, "how were patients doing who were seen in the past year?"

One step in report validation is looking at the SQL code in Relevant. Some general suggestions are made in the sections below to ensure that the Transformers, Importers and Quality Measure code is following the recommended and standard set-up. Some knowledge if SQL coding is needed for these functions.

The Data Validation sections for the measures below reference a set of validation reports that have been developed by RCHC. See the document "Instructions for Using the Relevant Validation Report Set" for more detail. This document that can be obtained from RCHC.

Obtaining Quality Measure Data in Relevant

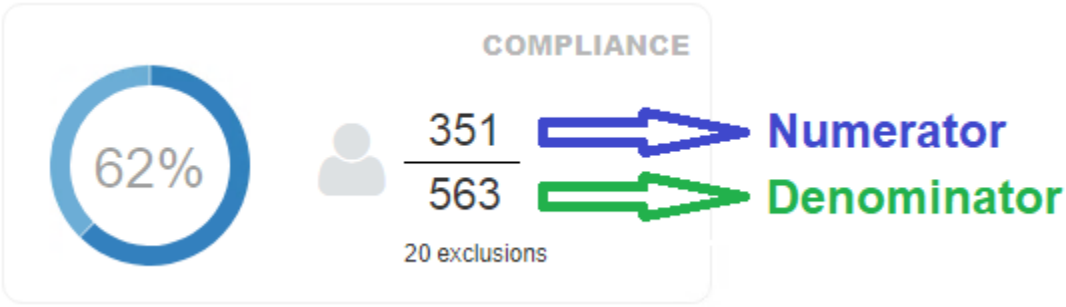
All of the PIP measures have equivalent Quality Measures in Relevant. The data is obtained in a similar manner for each one.

The instructions below display the current Relevant Quality Measure names to use for the measures. Note that the 2020 versions of the Quality Measures are used except for "Controlling High Blood Pressure." The definition of this Quality Measure will change in 2020, but the PIP will continue to use the 2019 definition. The other three measure definitions are not changing.

To obtain data in Relevant, navigate to the Quality Measures section of the webpage and find the Quality Measure you are interested in by scrolling down or using the name filter at the top of the page. Select the measure by clicking on the name.

Because you will be reporting on a Measurement Period that ended in a previous month, the default Measurement Period on the measure webpage must be changed. Use the appropriate year-long Measurement Period ending with the date that corresponds to the end of the quarter you are reporting. For example, in Relevant, the date parameter field looks like this when reporting after the end of 2020:

Once the correct Measurement Period is entered, the numerator and denominator appear in the "Compliance" box. These are reported to RCHC.



Blood Pressure Control Among Patients With Hypertension

Quality Measure Name: Controlling High Blood Pressure - 2019 QIP

Data Validation: The Quality Measure defines denominator patients with hypertension using the Importer "Essential Hypertension Cases." These patients have a standard diagnosis on their Problem List (the standard diagnoses are defined by the Value Set IOD = "2.16.840.1.113883.3.464.1003.104.12.1011"). Ensure that the Importer and/or Transformer is capturing the correct diagnosis codes.

It is important that the Importer displays patients who actually have essential hypertension and does not display patients who do not have essential hypertension. The report "RCHC Problem List Validation Report" can be used in Relevant to display patients who do NOT have a code for essential hypertension on the Problem List but a code for essential hypertension appeared on an encounter assessment or claim in the past year. The report also shows patients with a code for essential hypertension on the Problem List but a code for essential hypertension has NEVER appeared on an encounter assessment or claim in the past. In both of these cases, a confirmation of the clinical diagnosis is necessary, and then a code for essential hypertension is added to or removed from the Problem List, as appropriate.

Additional Note: This quality measure follows the QIP/HEDIS recommendations for Telehealth Impact on clinical measure reporting. Therefore, in addition to blood pressure measurements taken by staff in a clinical setting, readings from an automated and validated digital blood pressure measurement device operated by the patient outside of a clinical setting are also acceptable. These readings can be taken and reported by the patient. Below are five kinds of blood pressures acceptable for reporting this measure:

1. Blood pressure taken by an appropriately trained staff member in a clinical setting
2. Blood pressure readings from a remote device that are digitally stored and transmitted directly to the electronic health record
3. Blood pressure readings from a remote device that an appropriately trained staff member can confirm visually during an E-visit or virtual check
4. Self-reported blood pressure readings from a digital device collected verbally from the patient by an appropriately trained staff member during an outpatient visit, telephone visit, e-visit, virtual check-in, or remote monitoring event
5. Self-reported blood pressure readings from a digital device sent to the health center via the patient portal or e-mail

Note that this definition differs from the HRSA/UDS blood pressure definition because it allows a patient to communicate self-monitored blood pressure reading to the provider (e.g., verbally or by entering the result into a patient portal) without further verification.

It is strongly recommended that health centers develop a precise methodology to be able to electronically separate blood pressure measurements taken by trained staff in a clinical setting or verified during a video visit (#1 through #3 above) from those blood pressures reported by not directly verified by trained staff (#4 and #5 above). Options to separate them include having a distinct field for self-monitored/self-reported blood pressures, or an electronic procedure for identifying the visit type in combination with the reading. The QIP Controlling Blood Pressure Quality Measure accepts all types of blood pressure readings by default, and so further separation is not needed[1].

Blood Sugar Control Among Patients With Diabetes

Quality Measure Name: Diabetes: Hemoglobin A1c Control (<=9%) (UDS 2020 Table 7, inverted)

Data Validation: The Quality Measure defines denominator patients with diabetes using the Importer "Diabetes Cases." These patients have a standard diagnosis on their Problem List (the standard diagnoses are defined by the Value Set IOD = "2.16.840.1.113883.3.464.1003.103.12.1001"). Ensure that the Importer and/or Transformer is capturing the correct diagnosis codes.

It is important that the Importer displays patients who actually have diabetes and does not display patients who do not have diabetes. The report "RCHC Problem List Validation Report" can be used in Relevant to display patients who do NOT have a code for diabetes on the Problem List but a code for diabetes appeared on an encounter assessment or claim in the past year. The report also shows patients with a code for diabetes on the Problem List but a code for diabetes has NEVER appeared on an encounter assessment or claim in the past. In both of these cases, a confirmation of the clinical diagnosis is necessary, and then a code for diabetes is added to or removed from the Problem List, as appropriate.

To define the numerator, the report identifies hemoglobin A1c labs using the Importer "A1c Labs." These labs have standard LOINC codes (defined by the Value Set IOD = "2.16.840.1.113883.3.464.1003.198.12.1013"). To see all of the labs in your system that correspond to

[1] However, the UDS version of the Quality Measure must make this distinction, and so the approach that the health center chooses must be programmed into the Relevant blood pressure Transformer and Importer.

these LOINC codes, use the report "RCHC List of QM Lab Names and Attributes." Ensure that the Importer and/or Transformer is capturing all of the correct labs and not missing any.

Once you know that the Quality Measure is capturing the correct A1c tests, use the report "RCHC Incomplete Labs Validation Report" to identify any A1c labs that appear to have been done, but are missing essential data. Note that this lab requires that a numerical value appear in the Lab Value field.

The 2020 version of the Quality Measure defines some additional exclusions for patients who may be close to end-of-life. Therefore, ensure that Importers are properly established that capture Value Set diagnosis codes for frailty cases (Value Set IOD = "2.16.840.1.113883.3.464.1003.113.12.1074" and "2.16.840.1.113883.3.464.1003.113.12.1075") and advanced illness cases (Value Set IOD = "2.16.840.1.113883.3.464.1003.110.12.1082"), as well as for dementia Medications (Value Set IOD = "2.16.840.1.113883.3.464.1003.196.12.1510"). Furthermore, create Importers if your system is capturing patients receiving hospice care or living in a long-term in institution.

Colorectal Cancer Screening

Quality Measure Name: Colorectal Cancer Screening (UDS 2020 Table 6B)

Data Validation: The Quality Measure definition excludes patients who had a total colectomy performed or had colorectal cancer. This information must be entered into the health record in a standard manner, which had been defined by the RCHC Data Standards and Integrity Committee. Use the "RCHC Cancer Exclusion Validation Report" to list any patients that have some general evidence of an exclusion, but do not have the specific and standard wording. If the patient qualifies for an exclusion, amend the health record in a standard manner by adding a recommended diagnosis code to the Problem List or using the specific and standard key words in Surgical History or Medical History

To define the numerator, the report identifies FOBT and FIT labs using the Importers "Fecal Occult Blood Tests" and "Stool DNA Tests." These labs have standard LOINC codes (defined by the Value Set IOD = "2.16.840.1.113883.3.464.1003.198.12.1011" and "2.16.840.1.113883.3.464.1003.108.12.1039"). To see all of the labs in your system that correspond to these LOINC codes, use the report "RCHC List of QM Lab Names and Attributes." Ensure that the Importer and/or Transformer is capturing all of the correct labs and not missing any.

Once you know that the Quality Measure is capturing the correct FOBT and FIT labs, use the report "RCHC Incomplete Labs Validation Report" to identify any of these labs that appear to have been done, but are missing essential data.

There is a similar report named "RCHC Incomplete Images Validation Report" that displays colonoscopy and sigmoidoscopy records that may be incomplete. Note that the measure accepts a colonoscopy done up to 10 years in the past and a sigmoidoscopy up to 5 years in the past. Therefore, adjust the measurement period of the validation report accordingly in order to find any images in those time-frames.

The 2020 version of the Quality Measure defines some additional exclusions for patients who may be close to end-of-life. Note that these are the same Importers as described in the Diabetes measure section above.

Well-Child Visits in the First 15 Months of Life

Quality Measure Name: Well-Child Visits in the First 15 Months of Life: 6+ Well-Child Visits

Data Validation: No additional validation activities are recommended for this measure. However, make sure that the Importer is defining "well-child" visits in a way that makes sense and is valid.