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# QIP 2021 Quality Measure and Report Notes and Set-up Instructions (Version 1)

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Serving Sonoma, Napa, Marin & Yolo Counties

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# QIP 2021 Quality Measure and Report Set Instructions (Version 1)

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# QIP 2021 Quality Measure and Report Set Instructions (Version 1)

## Introduction

A set of twelve Quality Measures and two Reports have been created in Relevant to produce results for the 2021 Partnership HealthPlan QIP Clinical Domain and Unit of Service measures. This instruction manual describes the Quality Measures and Reports in general as well as the appropriate set-up of the Importers and data validation. It is for health centers using either eCW or NextGen.

The Unit of Service measures are limited to the two that rely on data from the EHR. Because Partnership payments for Unit of Service measures are based on the quantity of services (not the quality), these measures appear in Reports and not Quality Measures because they are not tracked over time with a denominator and numerator.

The twelve QIP Quality Measures work in a standard manner like other kinds of Quality Measures that appear in Relevant. Therefore, they can be examined for different measurement periods and filtered using the standard fields like location and provider. The measurement period is always assumed to be one year in length. Although the SQL code can be copied to DataGrip or a Relevant Report, it has not been designed or tested to be accurate for measurement periods of variable lengths.

Most of the 2021 Quality Measures have been reported historically or are similar to existing UDS Quality Measures. Therefore, the SQL code of the 2021 Quality Measures borrows heavily from pre-existing SQL code developed by Relevant or RCHC programmers. Some aspects of the code have been standardized so that data is being pulled in the same manner among all QIP reports. Generally, the results should agree with previous Quality Measure versions or UDS Quality Measures except where the measure definitions are different.

All Quality Measures and Reports in this set currently follow the 2021 QIP Measure Specifications as outlined in the Partnership document “Primary Care Provider Quality Improvement Program (PCP QIP) Specifications, Published: January 8, 2021.” The 2021 specifications did not contain as much detail as those in prior years. Therefore, where appropriate, some definitions and design elements were taken from the 2020 QIP measure specifications document, the Quality Measure Highlights<sup>1</sup>, and the HEDIS 2021 documentation.

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<sup>1</sup> The Quality Measure Highlights (referred to hereafter as the “QM Highlights”) are 2-5 page resources about each Primary Care Provider Quality Improvement Program (PCP QIP) measure. They can be accessed here: <http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Measure-Highlights.aspx>

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### General notes on the code and the set-up of the subqueries in each report

All Quality Measures and Reports rely on the Relevant Analytics Database (also known as the Production Database) and contain the same SQL code for all health center instances of Relevant. Like with the UDS measures, this approach assumes that the data processing and analysis will be the same at each health center, but that each health center is responsible for establishing and maintaining their own Transformers and Importers that extract the desired data from their Electronic Health Record (EHR). It is primarily on the level of the Transformers that customization is required because different health centers use different EHRs (eCW and NextGen) and have different set-ups, unique fields and settings, or distinctive data entry workflow or procedures.

In the instructions below, references are only made to the Importers because in the Relevant model, Importers are standardized among the health centers. Generally, the SQL code used to pull the data from the underlying EHR tables exist in the Transformers while the Importers are used to format the Transformer data into a defined structure. However, in some cases, the Importer contains the SQL code to pull the data directly. Therefore, when the instructions below reference Importer names, it is understood that the health center may need to first look at the Importer, but more likely, the associated Transformer contains the SQL code that is actually doing the work.

Some comments in the Report Notes sections below discuss the expected data coming from the Importers. For example, it may say that data from a particular Importer needs to be unduplicated, contain data in certain fields, or have another expected structure. No new Importers are needed for the 2021 Quality Measures or Reports. Many of the UDS and the QIP Quality Measures share the same Importers because the eCQM and HEDIS Value Sets are the same. For example, the Importer `essential_hypertension_cases` is used in both the QIP and UDS Quality Measures for Controlling High Blood Pressure because both QIP and UDS Value Sets contain the same diagnostic codes. There are not separate sets of QIP and UDS Importers.

All of the SQL code in the QIP Quality Measure set follows a common structure to make it easier for health center programmers to view and understand. For example, no field aliases appear in the SQL code (except the childhood immunization measure) and notes are used liberally. The SQL is broken up into various sub-queries that create Temporary Tables. The first subquery is the “universe,” which defines the basic denominator of the measure. Then, there is a numerator subquery that begins with a note “-- Numerator:” and a definition of the numerator itself. The next subquery features a note “-- Exclusion:” and a definition. The last subquery displays a note “-- Results query” and produces an output

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with the five standard fields that are used by the Relevant software to display the Quality Measure data in graph form and allow for filtering.

As mentioned previously, there are separate QIP and UDS Quality Measures, even for those measures with similar names and similar broad descriptions. It is highly unlikely that the denominator and numerator of a QIP measure (in default version) will be exactly the same as the denominator and numerator of a similar UDS measure for the same measurement period. Even though there has been a national effort to “standardize” the measures, there are still subtle differences in the definitions from each measure steward<sup>2</sup> and even differences in how each funding agency specifically deviates from those standards<sup>3</sup>.

It is recommended that health centers thoroughly validate the QIP Quality Measure and Report set before activating and using them for clinical or reporting purposes. Since RCHC is the author of these reports, questions should be directed to the RCHC data department. The most efficient way to describe a discrepancy is to provide as much detail as possible so that specific records in question can be examined by the RCHC programmers directly. For example, record identifiers, dates, values, etc. are extremely helpful. A discrepancy is where the Quality Measure is displaying or not displaying some data about a specific record that can be verified in the EHR. In contrast, it is less helpful to generally ask why the QIP and UDS measurement results are different or to ask questions about the results without thoroughly understanding the measure definitions.

### Swapping out the default denominator for the true QIP denominator

The initial structure of the Quality Measure SQL code defines a “universe” of patients. Each denominator is defined in the sections below under the heading Default Denominator Description. Generally, the denominator covers all EHR patients who qualify for the measure based on diagnosis or other characteristics (such as age, sex assigned at birth, etc.) and who had at least one medical encounter in the Measurement Period. Therefore, the default denominator is much broader than the actual denominator supplied by Partnership HealthPlan, even if filtered for EHR patients with current Partnership insurance.

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<sup>2</sup> HEDIS for Partnership and CMS for the UDS

<sup>3</sup> Perhaps to streamline reporting, the specific instructions in the respective manuals occasionally leave out criteria or have different criteria than the original detailed and standard specifications from the measure steward

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It is expected that sometime in 2021, all health centers will have a routine to download denominator patient data from Partnership HealthPlan and be able to store it in Relevant<sup>4</sup>. This will allow the Quality Measures to be connected directly to the appropriate Partnership patient denominator population. The health center should modify the SQL code in each 2021 Quality Measure and Report so that the default denominator is replaced by the actual monthly Partnership universe when it becomes available in Relevant<sup>5</sup>. In this case, the 2021 Quality Measures and Reports would therefore display Partnership denominator and the EHR numerator<sup>6</sup>.

The SQL code for the Quality Measures has been designed for easy transition to this scenario. For each Quality Measure, the patient universe is defined in the first subquery commonly named “universe” (as in “CREATE TEMPORARY TABLE universe AS...”). When the Partnership universe is available for the measure, it can be used in place of the code in this subquery. Note, however, that the “universe” subquery still needs to exist because it is joined to other subqueries later in the SQL code. Furthermore, key fields on the universe Temporary Table (i.e., patient\_id, provider\_id, and location\_id) are also displayed in the final results subquery.

For all Quality Measures, the denominator contains patients who have been “continuously enrolled” in Partnership HealthPlan managed care insurance. These patients are assigned to the health center on the first of the month for nine out of the 12 months in the past year. For the final denominator used to calculate payment (i.e., between January 1 and December 31 of the current measurement year), the patient must also be assigned on the “anchor date,” which is December 1st. The default version of the Quality Measures includes all patients (regardless of insurance) who meet the measure-specific denominator criteria and were seen at least once in the past year (i.e., in the 12 months prior to the end of the measurement period). Some measure definitions, such as the diabetes and hypertension measures, stipulate two visits in the past two years. However, without the continuous enrollment criterion, it does not make sense to add this to the default version of the Quality Measures. Therefore, any criteria for visits beyond the year-long measurement period are ignored.

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<sup>4</sup> This is not a requirement, but it is helpful for performance improvement and reporting purposes.

<sup>5</sup> This topic was discussed in the April 13, 2021 Data Workgroup meeting. The presentation slides and webinar recording are available from RCHC

<sup>6</sup> Further modification to the SQL code could consider adding the Partnership-derived numerator in cases where the patient is considered numerator-compliant by Partnership but not by the EHR. Another custom report could be developed to display patients who are considered numerator-compliant by the EHR but not by Partnership so that this data can be reported through eReports. These suggested tools have not been developed by RCHC.

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### End of life conditions

Some measures exclude patients who have certain conditions indicating they are at the end of their life. These include the three cancer screening measures, along with the diabetes and hypertension measures. The exclusion criteria for the QIP reports, as defined by Partnership and HEDIS, are the same as those for the UDS reports with one exception. The exception is that HEDIS considers patients with palliative care to be excluded from the QIP measures, whereas this is not specifically mentioned by the UDS instructions or related eCQMs for the same measures.

Therefore, for these QIP Quality Measures (but not cervical cancer, which is explained below), end-of-life conditions have any of the following characteristics:

- Patients in hospice or palliative care overlapping the measurement period
- Patients over 65 years of age (relative to the end of the measurement period) who stayed in long-term care for at least 90 days during the measurement period
- Patients over 65 years of age (relative to the end of the measurement period) who had a diagnosis of frailty (defined by the value set) along with at least one of the following:
  - ✓ Diagnosis of advanced illness (defined by the value set) in the two years prior to the end of the measurement period
  - ✓ Dementia medications in the two years prior to the end of the measurement period

Since the cervical cancer screening measure includes patients up to 65 years of age, the exclusion definition only features hospice or palliative care overlapping the measurement period. In the sections for all measures below, exclusions are listed under the heading “Exclusion Description.”

The following Importers are used for these exclusions. They should be linked to the appropriate Value Set as defined in the Appendix.

- hospice\_care\_interventions
- palliative\_care\_cases
- long\_term\_care\_stays
- frailty\_cases
- advanced\_illness\_cases
- dementia\_medications

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### Notes on descriptive sections below

Each section below describes one Quality Measure or Report. They have a standardized arrangement of headings. The description of the headings are as follows:

- **Quality Measure/Report Name:** The Quality Measure or Report name, as it appears in Relevant.
- **Version:** The version text, as it appears in the SQL header.
- **Measure Description:** A general description of the measure (used for the design of the default version).
- **Default Denominator Description:** The denominator definition used for the design of the default version. Note that the default version measures all patients who meet the denominator definition, not only patients defined by Partnership HealthPlan as being in the denominator.
- **Numerator Description:** The numerator definition used for the design of the default version.
- **Exclusion Description:** The exclusion definition used for the design of the default version.
- **Report Notes:** Additional notes that are helpful in understanding the design of the Quality Measure or Report, setting-up the Quality Measure or Report in your instance of Relevant, and interpreting the data.
- **Common Importers Used:** A list of Importers for patients, visits, and other data items commonly used by Quality Measures in Relevant.
- **Specific Importers Used:** A list of Importers that are unique to the Quality Measure or uncommon among the Quality Measures.
- **Data Validation:** Recommendations for ensuring the data required by the Quality Measure is complete and accurate. Separate validation reports can display missing or erroneous records that are necessary for the measure. Refer to the separate manual “Instructions for Using the Relevant Validation Report Set” available from RCHC.

The accuracy of all Importers and associated Transformers is important for these measures. Some comments under the Report Notes heading give additional descriptions of the data expected by the report from the Importers. It is recommended that Importers (or associated Transformers) directly utilize the designated Value Set for diagnosis, procedure, lab, and immunization codes. These Value Sets are updated by Relevant annually<sup>7</sup>. Nearly all of the Value Sets needed by the 2021 QIP Report Sets can be found on the eCQM Value Set table in Relevant. See the Appendix for a list of Value Sets recommended for the measures.

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<sup>7</sup> Therefore, a clause in the SQL needs to be present to select the most current Value Set

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## Clinical Domain Measures

### *Breast Cancer Screening*

Quality Measure: Breast Cancer Screening (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Breast Cancer Screening (UDS 2020 Table 6B)”

Measure Description: The percentage of female patients age 52 to 74 years who had appropriate breast cancer screening.

Default Denominator Description: Female patients age 52 to 74 years (at the end of the measurement period) with at least one medical visit in the measurement period.

Numerator Description: Denominator patients who had a mammogram within 27 months of the measurement period end date.

Exclusion Description: History of bilateral mastectomy, history of two unilateral mastectomies, in hospice, palliative care or had a long-term care stay during the measurement period, or a diagnosis of frailty and advanced illness.

Report Notes: The Importer “mastectomies” is key to defining perhaps the most common exclusion for this measure. It must be designed properly or there will be a risk of excluding too many patients from the denominator. The measure excludes patients who have had one complete bilateral mastectomy or two complete unilateral mastectomies. The Importer features a Boolean (i.e., TRUE or FALSE) field to indicate if the mastectomy was bilateral (field name “bilateral”) and also a field for the surgery date (field name “performed\_on”).

The Importer should correctly evaluate single unilateral mastectomies. Ideally, there should be an indication of left or right breast and a surgery date in the EHR, although this is not directly assessed or displayed by the Importer. In any case, the Importer should display one record for one unilateral mastectomy for one side with one surgery date. The measure SQL will count the number of unique records where the field bilateral is equal to FALSE. This represents a count of unilateral mastectomies

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and a patient is excluded when she has two unilateral mastectomies. However, if two records appear in the Importer for a single complete surgery on one side because they have different dates, it will be counted as two different sides done.

Common Importers Used: patients, visits, visit\_set\_memberships, long\_term\_care\_stays, hospice\_care\_interventions, palliative\_care\_cases, frailty\_cases, advanced\_illness\_cases, dementia\_medications

Specific Importers Used: mammograms, mastectomies

Data Validation: There is a standard approach to documenting breast cancer exclusions in the health record. These standards, as well as the recommended diagnosis codes and key text words, are defined in Appendix A of the RCHC document “Instructions for Using the Relevant Validation Reports.” Relevant Importers in the health center instance should follow these recommendations. The validation report “RCHC Cancer Exclusion Validation Report” (for both NextGen and eCW health centers) displays records that contain partial evidence of an exclusion, but do not meet the full standard. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

Mammograms are normally entered into the health record as images. There are particular criteria that define a complete image record. The validation report “RCHC Incomplete Image Validation Report” (for eCW health centers) displays image records that are partially complete. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

Furthermore, because mammogram results typically come from outside the health center, they must be added to the EHR as a Document, placed in the appropriate folder, and attached to an image order. Image documents that are not attached to an order are unlikely to be counted by the measure because the results contained in them are unlikely to have been put into structured data. The validation report “RCHC Unattached Lab and Image Validation Report” (for eCW health centers) displays image records that are not in the proper folder and/or not attached to an order. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

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## ***Cervical Cancer Screening***

Quality Measure: Cervical Cancer Screening (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Cervical Cancer Screening (UDS 2020 Table 6B)”

Measure Description: The percentage of female patients age 24 to 64 years who had appropriate cervical cancer screening.

Default Denominator Description: Female patients age 24 to 64 years (at the end of the measurement period) with at least one medical visit in the measurement period.

Numerator Description: Denominator patients who had cervical cytology performed within the last 3 years (for those 24 to 64 years of age at the time of the test) or had cervical cytology and high-risk human papillomavirus co-testing within the last 5 years (for those 30 to 64 years of age at the time of the test)

Exclusion Description: History of hysterectomy with no residual cervix, diagnosis of cervical agenesis or acquired absence of cervix, in hospice or palliative care during the measurement period.

Report Notes: Cervical cytology tests are defined by the Importer pap\_tests. These tests can be identified by the Value Set described in the Appendix. The 2021 QIP Instruction Manual states that biopsies are not valid for primary cervical cancer screening because they are diagnostic and therapeutic.

Like with other labs or images, documentation in the EHR must include a date that the cervical cytology or HPV test was done and a result or finding. The Importer should be examining the standard structured data fields for these items. Also note that test results that indicate that the cervical cytology lab sample was not actually evaluated (for example, a lab result like “no endocervical cells” or “inadequate sample”) should be excluded from the Importer results.

Common Importers Used: patients, visits, visit\_set\_memberships, hospice\_care\_interventions, palliative\_care\_cases

Specific Importers Used: pap\_tests, hpv\_tests, hysterectomies, congenital\_absence\_cervix\_cases

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Data Validation: There is a standard approach to documenting cervical cancer exclusions in the health record. These standards, as well as the recommended diagnosis codes and key text words, are defined in Appendix A of the RCHC document “Instructions for Using the Relevant Validation Reports.” Relevant Importers in the health center instance should follow these recommendations. The validation report “RCHC Cancer Exclusion Validation Report” (for both NextGen and eCW health centers) displays records that contain partial evidence of an exclusion, but do not meet the full standard. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

Pap tests are entered into the health record as labs. There are particular criteria that define a complete lab record. The validation report “RCHC Incomplete Lab Validation Report” (for both NextGen and eCW health centers) displays lab records that are partially complete. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

Furthermore, pap test results may also come from outside the health center. Therefore, they must be added to the EHR as a Document, placed in the appropriate folder, and attached to a lab order. Lab documents that are not attached to an order are unlikely to be counted by the measure. The validation report “RCHC Unattached Lab and Image Validation Report” (for eCW health centers) displays lab records that are not in the proper folder and/or not attached to an order. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

### ***Colorectal Cancer Screening***

Quality Measure: Colorectal Cancer Screening (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Colorectal Cancer Screening (UDS 2020 Table 6B)”

Measure Description: The percentage of patients age 51 to 75 years who had appropriate colorectal cancer screening.

Default Denominator Description: Patients between age 51 to 75 years (at the end of the measurement period) with at least one medical visit in the measurement period.

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Numerator Description: Denominator patients who had any of the following:

- Fecal occult blood test (FOBT) within one year of the end of the measurement period.
- FIT-DNA test within three years of the end of the measurement period.
- Flexible sigmoidoscopy within five years of the end of the measurement period.
- CT colonography within five years of the end of the measurement period.
- Colonoscopy within ten years of the end of the measurement period.

Exclusion Description: History of colorectal cancer, history of colectomy, in hospice, palliative care or had a long-term care stay during the measurement period, or a diagnosis of frailty and advanced illness.

Report Notes: Each of the labs or images that qualify for the numerator has its own Importer. Make sure that the Importers are identifying the appropriate image or lab (for example, lab LOINC codes are defined by a Value Set, and all Value Sets appear in the Appendix at the end of this document). Like with other labs or images, documentation in the EHR must include the date it was performed and a result or finding. The Importer should examine the standard structured data fields for these items. The measure displays only the last qualifying colorectal cancer screen entered into the system in the column `measurement_value`.

Common Importers Used: `patients`, `visits`, `visit_set_memberships`, `long_term_care_stays`, `hospice_care_interventions`, `palliative_care_cases`, `frailty_cases`, `advanced_illness_cases`, `dementia_medications`

Specific Importers Used: `fecal_occult_blood_tests`, `stool_dna_tests`, `sigmoidoscopies`, `ct_colonographies`, `colonoscopies`, `colorectal_cancer_cases`, `colectomies`

Data Validation: There is a standard approach to documenting colorectal cancer exclusions in the health record. These standards, as well as the recommended diagnosis codes and key text words, are defined in Appendix A of the RCHC document “Instructions for Using the Relevant Validation Reports.” Relevant Importers in the health center instance should follow these recommendations. The validation report “RCHC Cancer Exclusion Validation Report” (for both NextGen and eCW health centers) displays records that contain partial evidence of an exclusion, but do not meet the full standard. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

Fecal occult blood tests and FIT-DNA tests are entered into the health record as labs. There are particular criteria that define a complete lab record. The validation report “RCHC Incomplete Lab Validation Report” (for both NextGen and eCW health centers) displays lab records that are partially

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complete. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

Colonoscopies, sigmoidoscopies and CT colonographies are normally entered into the health record as images. There are particular criteria that define a complete image record. The validation report “RCHC Incomplete Image Validation Report” (for eCW health centers) displays image records that are partially complete. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

Furthermore, because colonoscopy, sigmoidoscopy and CT colonography results typically come from outside the health center, they must be added to the EHR as a Document, placed in the appropriate folder, and attached to an image order. Image documents that are not attached to an order are unlikely to be counted by the measure because the results contained in them are unlikely to have been put into structured data. The validation report “RCHC Unattached Lab and Image Validation Report” (for eCW health centers) displays image records that are not in the proper folder and/or not attached to an order. These records should be reviewed and corrected, if necessary. See the RCHC validation instructions document for more detail.

### ***Comprehensive Diabetes Management – HbA1c Good Control***

Quality Measure: Diabetes: HbA1c Good Control ( $\leq 9\%$ ) (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measures “Diabetes: Hemoglobin A1c Control ( $\leq 9\%$ ) (UDS 2020 Table 7, inverted)” and “Diabetes: HbA1c Good Control ( $\leq 9\%$ ) - 2019 QIP”

Measure Description: The percentage of patients age 18 to 75 years with diabetes who had an HbA1c test in the measurement period and the last test had a value of 9% or less.

Default Denominator Description: Patients age 18 to 75 years (at the end of the measurement period) with a diagnosis of diabetes, at least one medical visit in the measurement period.

Numerator Description: Denominator patients with at least one HbA1c test in the measurement period and the last test had a value of 9% or less.

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Exclusion Description: Diagnosis of gestational diabetes or steroid-induced diabetes during the two years prior to the end of the measurement period, in hospice, palliative care or had a long-term care stay during the measurement period, or a diagnosis of frailty and advanced illness.

Report Notes: The Importer diabetes\_cases should display patients with a diabetes diagnosis code on their Problem List. These codes belong to a Value Set defined in the Appendix at the end of this document. The Importer has columns for the diagnosis start date (column started\_on) and end date (column ended\_on), which are used to determine if the patient has a diagnosis overlapping the measurement period. Although diabetes is a chronic disease that normally cannot be “cured,” there may be cases where the diagnosis is clinically determined to be no longer appropriate or necessary. In this case, follow the standard protocol described by the EHR to remove the diagnosis from the Problem List. The Importer should contain SQL code that extracts and displays the date that the diagnosis was resolved (column ended\_on). Failing to do so will leave these patients in the denominator because it is assumed that if a patient has a diagnosis without an end date, the diagnosis is still active.

This measure excludes patients with a diagnosis of gestational diabetes or steroid-induced diabetes. There are no Importers for these diagnoses in the Relevant standard model. Therefore, for this QIP Quality Measure alone, the diagnosis codes are identified directly by the report in the exclusions Temporary Table. Since these diagnoses typically arise from time-limited conditions (for example, pregnancy or medications), they are obtained from visit diagnoses rather than the Problem List.

Common Importers Used: patients, visits, visit\_set\_memberships, long\_term\_care\_stays, hospice\_care\_interventions, palliative\_care\_cases, frailty\_cases, advanced\_illness\_cases, dementia\_medications, visit\_diagnosis\_codes, diagnosis\_codes

Specific Importers Used: diabetes\_cases, a1c\_labs

Data Validation: Patients with a current clinical diagnosis of diabetes are the focus of this report. For the default version, the standard is to use the Problem List in the EHR as the official source of diagnosis “truth.” The validation report “RCHC Problem List Validation Report” (for both NextGen and eCW health centers) displays records that suggest the patient should be considered for the addition of a diabetes diagnosis to the Problem List, or should be considered for removal of the diagnosis from the list, based on other evidence in the health record. These records should be reviewed and corrected, if necessary, in order to minimize the number of false positives and false negatives in the measure denominator. See the RCHC validation instructions document for more detail.

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Hemoglobin A1c tests are entered into the health record as labs. There are particular criteria that define a complete lab record. The validation report “RCHC Incomplete Lab Validation Report” (for both NextGen and eCW health centers) displays lab records that are partially complete. These records should be reviewed and corrected, if necessary. See the RCHC validation report instructions document for more detail.

### ***Controlling High Blood Pressure***

Quality Measure: Controlling High Blood Pressure (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measures “Controlling High Blood Pressure (UDS 2020 Table 7)” and “Controlling High Blood Pressure - 2019 QIP”

Measure Description: The percentage of patients age 18 to 85 years with essential hypertension who had a blood pressure in the measurement period and the last blood pressure reading had a value below 140/90 mmHg.

Default Denominator Description: Patients age 18 to 85 years (at the end of the measurement period) with a diagnosis of essential hypertension, at least one medical visit in the measurement period.

Numerator Description: Denominator patients with at least one blood pressure in the measurement period and the last blood pressure had a value below 140/90 mmHg.

Exclusion Description: Diagnosis of pregnancy during the measurement period, diagnosis of end-stage renal disease (ESRD), dialysis, or kidney transplant, in hospice, palliative care or had a long-term care stay during the measurement period, or a diagnosis of frailty and advanced illness.

Report Notes: The sources of blood pressure readings accepted by this Quality Measure follow the HEDIS guidelines and differ somewhat from the sources accepted by HRSA for the UDS report. Generally, the HEDIS/QIP accepts more sources than HRSA/UDS. The QM Highlights document states “Eligible readings include BP readings taken during an outpatient visit, telephone visit, e-visit or virtual check-in, or remote monitoring event (BP taken by any digital device).” The HRSA/UDS definition does not include self-reported/non-verified blood pressure readings. The table on the next page explains that statement in more detail.

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Blood pressure measurement	HEDIS/QIP	HRSA/UDS
Blood pressure taken by an appropriately trained staff member in a clinical setting	Yes	Yes
Blood pressure readings from a remote device that are digitally stored and transmitted directly to the electronic health record	Yes	Yes
Blood pressure readings from a remote device that an appropriately trained staff member can confirm visually during an E-visit or virtual check	Yes	Yes
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	Yes	No
Self-reported blood pressure readings from a digital device sent to the health center via the patient portal or e-mail	Yes	No

In the September 2020 Data Standards and Integrity Council (DSIC) meeting, it was agreed that health centers should develop their own approach to identifying non-verified Self-Monitored Blood Pressures (SMBP) in their EHR. Health centers should then distinguish non-verified SMBP in Relevant by configuring the field `exclude_from_uds` on the Importer `blood_pressure_readings` to read TRUE.

Since the HEDIS/QIP standards accept all blood pressures, the measure SQL code does not consider the field `blood_pressure_readings.exclude_from_uds` at all. However, the health center should ensure that all blood pressures being entered into the EHR are displayed by the blood pressure Importer and that the blood pressure exclusion field on that Importer is working for the UDS version of the measure.

Common Importers Used: `patients`, `visits`, `visit_set_memberships`, `long_term_care_stays`, `hospice_care_interventions`, `palliative_care_cases`, `frailty_cases`, `advanced_illness_cases`, `dementia_medications`

Specific Importers Used: `essential_hypertension_cases`, `blood_pressure_readings`, `end_stage_renal_disease_cases`, `dialysis_treatments`, `renal_transplants`, `pregnancy_observations`

Data Validation: Patients with a current clinical diagnosis of essential hypertension are the focus of this report. For the default version, the standard is to use the Problem List in the EHR as the official source of diagnosis “truth.” The validation report “RCHC Problem List Validation Report” (for both NextGen and

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eCW health centers) displays records that suggest the patient should be considered for the addition of an essential hypertension diagnosis to the Problem List, or should be considered for removal of the diagnosis from the list, based on other evidence in the health record. These records should be reviewed and corrected, if necessary, in order to minimize the number of false positives and false negatives in the measure denominator. See the RCHC validation report instructions document for more detail.

### ***Well-Child Visits in the First 15 Months of Life***

Quality Measure: Well-Child Visits in the First 15 Months of Life (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “W15 - Well-Child Visits in the First 15 Months of Life: 6+ Well-Child Visits”

Measure Description: The percentage of children turning 15 months of age in the measurement period who had six or more well-child visits

Default Denominator Description: Patients who turned 15 months of age (1 year + 30 days) in the measurement period and had at least one medical visit in the measurement period

Numerator Description: Denominator patients with at least six well-child visits, at least 14 days apart, before turning 15 months of age.

Exclusion Description: hospice care in the measurement period

Report Notes: There are two QIP measures that consider well-child visits. They differ by age range and number of visits required. However, the CPT and ICD-10 codes used to define a well-child visit are the same for both reports. Therefore, the Importer well\_child\_interventions can be used for both. Since well-child visits are only considered by a QIP Quality Measure, the QIP Value Set “Well-Care” should be used to define the codes. It is not recommended that health centers assume that patients with a particular visit type or who saw a particular provider actually meet the criteria as having a well-child visit in the absence of the specified CPT or ICD-10 codes. The 2020 version of the QIP instructions gives an example of the kind of documentation that is required for a well-child exam, although this is not directly evaluated by the report.

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Note that the Well-Child Value Set contains both procedure (CPT) codes and diagnosis (ICD) codes. Therefore, the Importer “well\_child\_interventions” should pick up both<sup>8</sup>. The QM highlight for this measure displays both CPT and ICD codes that define well-child visits.

Note that well-care visits must be at least 14 days apart in order to be counted by the report. Therefore, it might be the case that the number of visits in the EHR differs from the count on the report unless the 14 day rule is manually applied.

The QM Highlight for this measure states that the “well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.” This provision must be considered on the level of the Importer well\_child\_interventions. The Quality Measure SQL assumes that all well-child visits identified by that Importer meet all of the criteria defined by Partnership HealthPlan and counts them accordingly.

It is important to note that the default denominator definition includes patients who had at least one medical visit of any kind in the Measurement Period. This approach is the same as the other Quality Measure default denominators but will tend to bias the measure to a higher numerator percentage than if the actual Partnership-supplied denominator is used. The reason for this is because this measure looks at patients who have had visits to the health center. However, with the default denominator, we are not really sure who is *supposed* to have a visit because if they have not been seen in the Measurement Period, we do not even know if they are still in the area, still the health center’s patients, etc. The assumption is therefore to take patients who are known to have access to health services, which in this case, are patients seen recently. However, a bias occurs because those in this age group who are seen for any medical visit are likely to be seen for a well-child visit.

In contrast, the denominator supplied by Partnership HealthPlan contains only patients who they expect to have a well-child visit. This is true because these patients are continuously enrolled in Partnership insurance and assigned to the health center. In other words, they are measuring if indeed these patients *did* have a well-child visit. This list also contains patients enrolled in Partnership who were not seen for any visit at the health center but *should* have been seen for a well-child visit. It is impossible to identify these kinds of patients using only information in the EHR.

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<sup>8</sup> Recommending billing procedures is beyond the scope of these instructions. Because the QM Highlight document displays both the ICD and CPT codes present in the Value Set, it is assumed that the presence of any of these codes is sufficient to designate the visit as a “well-child visit.”

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Ideally, health centers should be using the Partnership denominator if they can. However, if not possible, health centers have the option of changing the visit range of the default denominator in the report. It was programmed for one a year, but it can look back 18 months or even two years, depending on how the health center has defined a “current patient.” The idea is to identify patients (i.e., current patients) who are reasonably expected to return for a well-child visit in the chosen time frame.

Keep in-mind that adding patients to the denominator from months or years prior to the beginning of the measurement period adds another kind of bias that tends to reduce the numerator percentage because it is unknown if these patients are still in the area or if they have chosen another provider. The further you go back in time for the last possible visit of a patient, the greater this bias will be. If allowing patients with a last visit before the beginning of the measurement period into the denominator, a health center may also choose to add criteria to the SQL code that only includes non-inactive and non-deceased patients.

Common Importers Used: patients, visits, visit\_set\_memberships, hospice\_care\_interventions

Specific Importers Used: well\_child\_interventions

Data Validation: There is not a separate validation report for this measure

### ***Child and Adolescent Well-Care Visits***

Quality Measure: Child and Adolescent Well-Care Visits (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Well Child Visits - 2019 QIP”

Measure Description: The percentage of children between 3 and 17 years of age who had at least one well-child visit in the measurement period.

Default Denominator Description: Patients age 3 to 17 years (at the end of the measurement period) and had at least one medical visit in the measurement period

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Numerator Description: Denominator patients with at least one well-child visit in the year prior to the end of the measurement period

Exclusion Description: hospice care in the measurement period

Report Notes: There are two QIP measures that consider well-child visits. They differ by age range and number of visits required. However, the CPT and ICD-10 codes used to define a well-child visit are the same for both reports. Therefore, the Importer well\_child\_interventions can be used for both. Since well-child visits are only considered by a QIP Quality Measure, the QIP Value Set “Well-Care” should be used to define the codes. It is not recommended that health centers assume that patients with a particular visit type or who saw a particular provider actually meet the criteria as having a well-child visit in the absence of the specified CPT or ICD-10 codes. The 2020 version of the QIP instructions gives an example of the kind of documentation that is required for a well-child exam, although this is not directly evaluated by the report<sup>9</sup>.

The QM Highlight for this measure states that the “visit must occur with a PCP or an OB/GYN practitioner (as applicable); the practitioner does not have to be the practitioner assigned to the member.” This provision must be considered on the level of the Importer well\_child\_interventions. The Quality Measure SQL assumes that all well-child visits identified by that Importer meet all of the criteria defined by Partnership HealthPlan and counts them accordingly.

It is important to note that the default denominator definition includes patients who had at least one medical visit of any kind in the Measurement Period. This approach is the same as the other Quality Measure default denominators but will tend to bias the measure to a higher numerator percentage than if the actual Partnership-supplied denominator is used. The reason for this is because this measure looks at patients who have had visits to the health center. However, with the default denominator, we are not really sure who is *supposed* to have a visit because if they have not been seen in the Measurement Period, we do not even know if they are still in the area, still the health center’s patients, etc. The assumption is therefore to take patients who are known to have access to health services, which in this case, are patients seen recently. However, a bias occurs because those in this age group who are seen for any medical visit are likely to be seen for a well-child visit.

In contrast, the denominator supplied by Partnership HealthPlan contains only patients who they expect to have a well-child visit. This is true because these patients are continuously enrolled in Partnership

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<sup>9</sup> This description appears in the section for the old measure, “Adolescent Well-Care Visits (12 – 21 Years Old)” but the documentation is the same.

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insurance and assigned to the health center. In other words, they are measuring if indeed these patients *did* have a well-child visit. This list also contains patients enrolled in Partnership who were not seen for any visit at the health center but *should* have been seen for a well-child visit. It is impossible to identify these kinds of patients using only information in the EHR.

Ideally, health centers should be using the Partnership denominator if they can. However, if not possible, health centers have the option of changing the visit range of the default denominator in the report. It was programmed for one a year, but it can look back 18 months or even two years, depending on how the health center has defined a “current patient.” The idea is to identify patients (i.e., current patients) who are reasonably expected to return for a well-child visit in the chosen time frame.

Keep in-mind that adding patients to the denominator from months or years prior to the beginning of the measurement period adds another kind of bias that tends to reduce the numerator percentage because it is unknown if these patients are still in the area or if they have chosen another provider. The further you go back in time for the last possible visit of a patient, the greater this bias will be. If allowing patients with a last visit before the beginning of the measurement period into the denominator, a health center may also choose to add criteria to the SQL code that only includes non-inactive and non-deceased patients.

Common Importers Used: patients, visits, visit\_set\_memberships, hospice\_care\_interventions

Specific Importers Used: well\_child\_interventions

Data Validation: There is not a separate validation report for this measure

### ***Childhood Immunization Status***

Quality Measure: Childhood Immunization Status (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Childhood Immunization Status (UDS 2020 Table 6B)”

Measure Description: The percentage of children turning two years of age in the measurement period who were fully immunized with ten vaccines.

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Default Denominator Description: Patients who turned two years of age in the measurement period and had at least one medical visit in the measurement period.

Numerator Description: Denominator patients with the following ten immunizations:

- 4 diphtheria, tetanus and acellular pertussis (DTaP) between 42 days old and second birthday
- 3 polio (IPV) between 42 days old and second birthday
- 3 haemophilus influenza type B (HiB) between 42 days old and second birthday
- 4 pneumococcal conjugate (PCV) between 42 days old and second birthday
- 1 measles, mumps and rubella (MMR) on or between the first and second birthdays
- 1 chicken pox (VZV) on or between the first and second birthdays
- 1 Hepatitis A (HepA) on or between the first and second birthdays
- 3 hepatitis B (HepB) on or before the second birthday
- 2 or 3 Rotavirus (RV), depending on type, between 42 days old and second birthday
- 2 Influenza (Flu) between 181 days old and second birthday

For the immunizations MMR, VZV, HepA and HepB, a documented history of the illness or a seropositive test result for the antigen counts toward the numerator as well.

Exclusion Description: Hospice care in the measurement period or an anaphylactic reaction to any of the vaccines.

Additionally, for individual vaccines, the following apply:

- Encephalopathy due to vaccination: DTaP
- Immunodeficiency: MMR, VZV and Flu
- HIV: MMR, VZV and Flu
- Lymphoreticular cancer, multiple myeloma or leukemia: MMR, VZV and Flu

Report Notes: Vaccines in the numerator must have been given within age ranges specified in the section Numerator Description above. Vaccines given outside of those age ranges are not counted by the Quality Measure. Therefore, the vaccine counts on this report may appear different than what appears in the electronic medical record unless date ranges from the record are manually taken into consideration. Furthermore, the numerator percentage may appear lower when compared to other versions of Quality Measures or reports that only take into consideration if the vaccines were given any time before the patient's second birthday.

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Importers that display immunizations should display unique records like this: one patient with one vaccine administered on one date. If duplicate records appear or a single dose appears with different dates, then the report will over-count the number of vaccines. The names of these Importers end in “\_immunizations” (for example, mmr\_immunizations or flu\_immunizations).

There are two types of rotavirus vaccines, each with different CVX codes and a different Importer. These are the two-dose variety (Importer rv\_double\_dose\_immunizations) and the three-dose variety (Importer rv\_triple\_dose\_immunizations). The report does not allow mixing of doses, but rather will recognize the one with the most doses as the main one administered if at least one of each has been given to a particular patient. The QM Highlights document for this measure described the immunization requirement breakdown as “2 or 3 Rotavirus (RV) [given] between 42 days old and 8 months of age.” This requirement is what has been programmed into the report for Rotavirus.

Common Importers Used: patients, visits, visit\_set\_memberships, hospice\_care\_interventions

Specific Importers Used: dtap\_immunizations, mmr\_immunizations, flu\_immunizations, hep\_b\_immunizations, vzv\_immunizations, hep\_a\_immunizations, pcv\_immunizations, ipv\_immunizations, rv\_triple\_dose\_immunizations, rv\_double\_dose\_immunizations, hi\_b\_three\_dose\_immunizations, hi\_b\_four\_dose\_immunizations, dtap\_vaccine\_allergies, encephalopathy\_cases, ipv\_vaccine\_allergies, streptomycin\_allergies, polymyxin\_b\_allergies, neomycin\_allergies, measles\_cases, mumps\_cases, rubella\_cases, histiocytic\_tissue\_cancer\_cases, lymphoreticular\_tissue\_cancer\_cases, multiple\_myeloma\_cases, leukemia\_cases, immunodeficiency\_cases, hiv\_cases, mmr\_antigen\_labs, mmr\_vaccine\_allergies, neomycin\_allergies, hepatitis\_b\_cases, hep\_b\_antigen\_labs, hep\_b\_vaccine\_allergies, baker\_yeast\_allergies, chicken\_pox\_cases, vzv\_antigen\_labs, vzv\_vaccine\_allergies, pcv\_vaccine\_allergies, hepatitis\_a\_cases, hep\_a\_antigen\_labs, hep\_a\_vaccine\_allergies, rv\_vaccine\_allergies, flu\_vaccine\_allergies, hi\_b\_vaccine\_allergies

Data Validation: There is not a separate validation report for this measure

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### ***Immunizations for Adolescents***

Quality Measure: Immunizations for Adolescents (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Immunizations for Adolescents - 2019 QIP”

Measure Description: The percentage of children turning 13 years of age in the measurement period who were fully immunized with three vaccines.

Default Denominator Description: Patients who turned 13 years of age in the measurement period and had at least one medical visit in the measurement period.

Numerator Description: Denominator patients with the following three immunizations:

- One meningococcal conjugate vaccine (MCV) on or between the eleventh and thirteenth birthdays
- One tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine on or between the tenth and thirteenth birthdays
- Two human papillomavirus vaccines (HPV), with different dates of service at least 146 days apart, on or between the ninth and thirteenth birthdays or 3 HPV with different dates of service on or between the ninth and thirteenth birthdays

For each immunization, a documented history of the illness or a seropositive test result for the antigen counts toward the numerator as well.

Exclusion Description: Hospice care in the measurement period or an anaphylactic reaction to any of the vaccines. Furthermore, encephalopathy due to vaccination is an exclusion for the Tdap vaccine.

Report Notes: All vaccines must be given in the time frame indicated by the measure (see Numerator Description section above). Therefore, it may be possible that during an audit or other validation exercise, the medical record may show additional vaccines not administered in the defined time frame.

Importers that display immunizations should display unique records like this: one patient with one vaccine administered on one date. If duplicate records appear or a single dose appears with different dates, then the report will over-count the number of vaccines. The names of these Importers end in “\_immunizations” (for example, mcv\_immunizations).

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Note that there are two options for the human papillomavirus vaccine portion of the numerator. The Quality Measure evaluates both. The patient can enter the numerator if the dates of the first and last HPVs between the ninth and thirteenth birthdays are at least 146 days apart. If this is not true, the patient can also enter the numerator if the count of HPVs between the ninth and thirteenth birthdays is equal to three or more. If the patient had exactly two vaccines but they were under 146 days apart, the patient is not considered compliant and the column measurement\_value in the detailed results will read “HPV doses too close (shots 2/2).”

Common Importers Used: patients, visits, visit\_set\_memberships, hospice\_care\_interventions

Specific Importers Used: mcv\_immunizations, tdap\_immunizations, hpv\_immunizations, mcv\_vaccine\_allergies, tdap\_vaccine\_allergies, hpv\_vaccine\_allergies, meningococcal\_meningitis\_antigen\_labs, tetanus\_antigen\_labs, diphtheria\_antigen\_labs, pertussis\_antigen\_labs, hpv\_antigen\_labs, encephalopathy\_cases

Data Validation: There is not a separate validation report for this measure

### ***Counseling for Nutrition Counseling for Children/Adolescents***

Quality Measure: Counseling for Nutrition for Children/Adolescents (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (UDS 2020 Table 6B)”

Measure Description: The percentage of children between 3 and 17 years of age who had at least one nutrition counseling in the measurement period.

Default Denominator Description: Patients age 3 to 17 years (at the end of the measurement period) and had at least one medical visit in the measurement period

Numerator Description: Denominator patients who had nutrition counseling in the measurement period.

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Exclusion Description: Patients who were pregnant during the measurement period.

Report Notes: This measure is similar to the well-established UDS measure for weight assessment and counseling for nutrition and physical activity, but focuses only on the nutrition component and does not require that patients have BMI documented. There is a separate QIP measure for physical activity counseling. Both QIP reports have the same denominator.

Common Importers Used: patients, visits, visit\_set\_memberships, pregnancy\_observations

Specific Importers Used: nutrition\_counselings

Data Validation: There is not a separate validation report for this measure

### ***Counseling for Physical Activity for Children/Adolescents***

Quality Measure: Counseling for Physical Activity for Children/Adolescents (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (UDS 2020 Table 6B)”

Measure Description: The percentage of children between 3 and 17 years of age who had at least one physical activity counseling in the measurement period.

Default Denominator Description: Patients age 3 to 17 years (at the end of the measurement period) and had at least one medical visit in the measurement period

Numerator Description: Denominator patients who had physical activity counseling in the measurement period

Exclusion Description: Patients who were pregnant during the measurement period

Report Notes: This measure is similar to the well-established UDS measure for weight assessment and counseling for nutrition and physical activity, but focuses only on the physical activity component and

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does not require that patients have BMI documented. There is a separate QIP measure for nutrition counseling. Both QIP reports have the same denominator.

Common Importers Used: patients, visits, visit\_set\_memberships, pregnancy\_observations

Specific Importers Used: physical\_activity\_counselings

Data Validation: There is not a separate validation report for this measure

### ***Asthma Medication Ratio***

Quality Measure: Asthma Medication Ratio (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Asthma Medication Ratio - 2019 QIP”

Measure Description: The percentage of patients age 5 to 64 years with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement period.

Default Denominator Description: Patients age 5 to 64 years (at the end of the measurement period) with a diagnosis of persistent asthma, at least one medical visit in the measurement period, and at least one asthma medication dispensing event.

Numerator Description: Denominator patients who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The Asthma Medication Ratio Calculation is as follows:

$$\frac{\text{(Units of Controller Medication)}}{\text{(Units of Controller Medication + Units of Rescue Medication)}}$$

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Exclusion Description: Patients with a diagnosis of emphysema, other emphysema, chronic obstructive pulmonary disease (COPD), obstructive chronic bronchitis, chronic respiratory conditions due to fumes/vapors, cystic fibrosis or acute respiratory failure.

Report Notes: This Quality Measure is an approximation of the actual measure that will be calculated by Partnership HealthPlan. The QM Highlight says that the measure is “based on administrative data; there is no manual upload to eReports.” The actual denominator defined by HEDIS contains additional denominator criteria that consider Emergency Department visits and acute inpatient stays with a principal diagnosis of asthma. This information is typically not available in the health center EHR. Furthermore, the health center EHR contains information on prescriptions and refills given to the patient, but typically it is unknown in the EHR which medications were actually picked up at the pharmacy.

Therefore, the Quality Measure default denominator has been drastically simplified so that it focuses on patients with persistent asthma as well as at least one medical visit and at least one asthma medication dispensing event in the measurement period. If using the default denominator to track all patients, the Quality Measure should give a good perspective on medication ratio trends for quality purposes. But like with the other Quality Measures, it is recommended that the health center use the actual denominator supplied by Partnership to really focus on those patients with the complex array of visits and dispensing events defined by HEDIS.

The report identifies all patients with Persistent Asthma from the Importer asthma\_cases. These patients are defined by having a diagnosis start date before the end of the Measurement Period and the column persistent equal to TRUE. Note that this Importer does not have a column for end\_date (which is present, for example, on the Importer diabetes\_cases). Therefore, the Importer must not display any patients with an inactive diagnosis or with an otherwise resolved diagnosis. Ideally, one patient should not have both persistent and intermittent asthma diagnoses active at the time. However, in this case, the Quality Measure determines which diagnosis was the most recent one entered (or in other words, the one with the most recent started\_on date).

The Importer asthma\_medications identifies all of the Asthma Medications for this measure. When the Quality Measure was first developed, the medication names were hard-coded in the SQL. This list should be compared against the medication list in the Quality Measure Highlight<sup>10</sup>. At most health centers, NDC codes from the medication Value Set defined by HEDIS are not used directly by Relevant, therefore

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<sup>10</sup> This document is available on the Partnership HealthPlan website. Some Value Sets can also be viewed in eReports

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names are the obvious choice. Somebody knowledgeable should review the list of medications actually picked up by this Importer to make sure that no appropriate medications are missing or inappropriate medications included, and also that the type of medication is correct.

The Importer `asthma_medications` defines the type of each medication (oral, inhaler or injection) and the number of units dispensed (column `units_dispensed`). The units for inhalers and injections are pretty straightforward (i.e., 1 inhaler or 1 injection is one unit). However, the units for oral medications requires a calculation. The health center may need to examine how the package size and number of pills taken per day is entered into their EHR for oral asthma medications. The goal is to define one unit as a prescription lasting 30 days (or, in other words, divide the days supply by 30 and round-down). For example, if an oral medication has a package size lasting 30 days, it is one unit. A package size of 100 days is 3 units (100 divided by 30 and rounded down). Note that at many health centers, the package sizes are commonly 30 days, 60 days and 90 days (and so, 1, 2 or 3 units). Make sure that the Importer is interpreting these common package sizes correctly<sup>11</sup>.

Common Importers Used: `patients`, `visits`, `visit_set_memberships`

Specific Importers Used: `asthma_cases`, `asthma_medications`, `chronic_obstructive_pulmonary_disease_cases`, `cystic_fibrosis_cases`, `acute_respiratory_failure_cases`, `fumes_exposure_cases`

Data Validation: The default denominator of this report is focused on patients with a persistent asthma diagnosis on the Problem List. The validation report "RCHC Persistent Asthma Diagnosis Validation Report" can be used to "clean up" the Problem List and make the default denominator more accurate. The report suggests patients who should be examined more closely so a decision can be made to add a diagnosis code to the Problem List or remove the code from the Problem List, depending on the report findings. Preferably, each patient should be diagnosed with either persistent or intermittent asthma, but not both.

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<sup>11</sup> In eCW, for example, the field containing the days supply is a text field. Therefore, sometimes providers enter a number plus text like days, weeks, months, etc. or else no text at all. The Importer should be able to properly interpret the most common forms of text in this field for oral asthma medications.

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## Unit of Service

These measures are designed as Reports on the Relevant Staging Database. Similar to the Quality Measures, there is a single version of the report for eCW and NextGen health centers. These measures allow the health center to identify patients who may have received services that may be reimbursed by Partnership. Because a component of the measures relies on billing (CPT) codes, the health center can use the list to double-check the corresponding patient list from Partnership. It can also be used to identify patients who were not properly billed or who need an attestation of services.

As of the writing of the first version of these instructions, the RCHC Data Standards and Integrity Council has begun discussions on expanding the detail of information gathered by the health centers around advanced care planning and alcohol screening. The first version of these reports features only the basic information (i.e., the date of service). It is hoped that future versions available from RCHC will provide extra detail.

## *Advanced Care Planning*

Report Name: Advanced Care Planning (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Advance Care Planning - 2019 QIP”

Patients Displayed: Patients with a UDS visit in the Measurement Period and any of the following:

1. An Advance Directive and/or POLST documented in the EHR in the Measurement Period
2. A conversation in the measurement period about a previously-completed Advance Directive or POLST along with a note that the patient does not wish to make any changes
3. A documented discussion in the measurement period around social supports, patient preferences and likely course of action for acute illness, long term chronic illness or terminal illness, as well as “what ifs” for serious accidents

Exclusion Description: An Advanced Care Planning billing (CPT) code appearing on a claim in the Measurement Period. These codes are 99497 or 99498.

Report Notes: Health centers are eligible for reimbursement from Partnership HealthPlan when a patient creates an Advanced Directive or POLST and this is documented in the medical record. In the

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absence of a new Advanced Directive or POLST, reimbursement is also given when there is a documented conversation around an Advanced Directive or POLST already on file, or when education is done to inform the patient about the importance of creating one. Reimbursement is not provided when the health center has already billed Partnership for Advanced Care Planning through a claim in the Measurement Period.

The report displays all patients with an Advanced Care Plan activity that is identified by the Importer `advance_care_plannings`. If more than one date is present on that Importer, the last date is displayed on the report (column `measurement_value`). If the health center billed Partnership already, the last billing date is displayed in the column `exclusion_value`.

The Importer `advance_care_plannings` (or associated Transformer) should be designed to pick up all eligible Advanced Care Planning activities. These may be entered into structured data, saved as Documents, or entered into specialized fields in the EHR. Currently, the Importer only features the date of the conversation or entry of planning documentation, not the type of document or other details. However, health centers are encouraged to understand how Advanced Care Planning data is entered into their EHR and also design the Transformer to display helpful details for their own purposes.

As of the writing of this version of these instructions, there is discussion at the RCHC Data Standards and Integrity Council about expanding the function of the Importer `advance_care_plannings` in order to be able to track a similar measure for a non-QIP project. Therefore, this report may be modified some time in 2021 to provide more detailed information on Advanced Care Planning activities.

The current version of the report is intended to help identify patients with Advanced Care Planning services during the year that have not already been reimbursed. If the health center has the ability to replace the default Universe with Partnership HealthPlan patients, then the list can be narrowed down considerably. The default version of the report displays all patients regardless of age or insurance.

It is recommended that the health center verify that patients meet the required criteria by consulting the detailed documentation in the EHR. The report only lists possible candidates, so the health center should ensure that the services rendered to a particular patient are true before completing an attestation.

Lastly, the default version of the report only displays patients who have had Advanced Care Planning activities documented. If desired, once the health center is able to replace the default denominator with the actual Partnership denominator, the INNER JOIN to the Temporary Table `last_acp` in the results

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query can be changed to a LEFT JOIN in order to display Partnership patients who still need Advanced Care Planning.

Common Transformers Used: patients, visits, visit\_set\_memberships, payers, payer\_groups, locations, providers, health\_centers

Specific Importers Used: advance\_care\_plannings

Data Validation: There is not a separate validation report for this measure

### ***Alcohol Misuse Screening and Counseling***

Report Name: Alcohol Misuse Screening and Counseling (QIP 2021)

Version: 2021 Version 1. Based on SQL code modified from the Quality Measure “Alcohol Misuse Screening and Counseling (SBIRT) - 2019 QIP”

Patients Displayed: Patients with a UDS visit in the Measurement Period and at least one alcohol screening and counseling in the six-month measurement period.

Exclusion Description: No exclusions

Report Notes: Health centers are eligible for reimbursement from Partnership HealthPlan when a patient is screened and counseled for alcohol consumption. The incentive is paid per screening/counseling unit. The QIP instructions state that there is a “frequency limit of two screenings per individual patient within a six month time frame.” However, the report can be run for any length of Measurement Period.

This report displays all patients with both specified CPT codes G0442 (alcohol screening) and G0443 (alcohol counseling) during the visit within the six-month time-frame. The total number of services (i.e., the screening and the counseling taken as a single unit) per patient is displayed, along with the first and second visit dates. The QIP instructions state a screening rate formula, but the default version of this report does not attempt to make that calculation because the number of assigned adults is unknown.

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The report can be used to verify that Partnership recognizes that individual patients were screened. There is no attestation necessary for this measure.

Note that as of the writing of this version of these instructions, there is discussion at the RCHC Data Standards and Integrity Council about establishing standard alcohol screening and counseling fields, perhaps in Structured Data. There is currently no Importer for this in Relevant and focusing on the CPT codes described above offers limited information. Therefore, this report may be modified some time in 2021 to accommodate new data gathering and reporting activities. One possible upgrade may allow the user to see patients who had alcohol screening and counseling documented in the EHR but not billed on a claim, and therefore the report could be used for performance improvement purposes.

Lastly, the default version of the report only displays patients who have had alcohol screening and counseling activities documented. If desired, once the health center is able to replace the default denominator with the actual Partnership denominator, the first INNER JOIN to the SELECT statement with the alias "number" in the results query can be changed to a LEFT JOIN in order to display Partnership patients who still need alcohol screening and counseling. In this scenario, a screening rate among Partnership patients can also be calculated.

Common Transformers Used: patients, visits, visit\_set\_memberships, payers, payer\_groups, locations, providers, health\_centers, visit\_billing\_codes, billing\_codes

Specific Importers Used: Currently, no specific Importers are used for this measure

Data Validation: There is not a separate validation report for this measure

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### **Appendix: Value Sets Associated With the QIP Measures**

The QIP Quality Measures use Value Sets to define diagnosis (ICD), procedure (CPT), lab (LOINC), and immunization (CVX) codes. This ensures that all reporting health centers are extracting data in a standardized manner. For example, the diabetes value set includes all diagnosis codes for diabetes that are applicable to the Quality Measure. This relieves each health center of the burden to identify appropriate codes from their system. For example, not all diagnosis codes with a name containing the word “diabetes” is appropriate for identifying that Quality Measure population of patients with diabetes.

It is recommended that Importers (or associated Transformers) directly utilize the designated Value Set in the SQL code. If the health center uses additional codes as a matter of routine (or if the health center can identify records using key words in structured data or other means), these can be added after proper internal review. The RCHC Data Standards and Integrity Committee regularly makes recommendations for data standardization and many of these recommendations have been discussed in the instructions above.

The QIP measures officially use the HEDIS Value Sets and the UDS measures use the eCQM Value Sets. In most cases, these Value Sets are identical. There are not separate Value Sets in Relevant for QIP and UDS measures. Frequently, the eCQM Value Sets have already been utilized in Relevant. For measures that are not comparable, the QIP/HEDIS Value Set will need to be used.

The large table below lists the standard Importers for each QIP Quality Measure and Report, along with the associated Value Set. The ID numbers mostly reference eCQM Value Sets, except where noted. In Relevant, the table with the eCQM Value Set codes is named “cqm\_value\_set\_codes” and the table with the QIP Value Set codes is named “relevant\_qip\_2019\_value\_set.” The most recently updated Value Sets on the table are identified by the column latest = TRUE.

Note that the Value Sets pick up codes only. If your health center has other ways of recognizing the required data (for example, it is entered into structured data), then those should be considered as well. In other words, Value Sets are the standard and recommended approach, but appropriate alternatives may exist.

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Quality Measure or Report Name	Importer	Value Set Name (default eCQM, except where noted)	OID (eCQM identifier)	Value Set Type
Breast Cancer Screening (QIP 2021)	mammograms	No applicable Value Set (see Note #1)		
	mastectomies	History of bilateral mastectomy	2.16.840.1.113883.3.464.1003.198.12.1068	Diagnosis
		Status Post Left Mastectomy	2.16.840.1.113883.3.464.1003.198.12.1069	Diagnosis
		Status Post Right Mastectomy	2.16.840.1.113883.3.464.1003.198.12.1070	Diagnosis
		Unilateral Mastectomy, Unspecified Laterality	2.16.840.1.113883.3.464.1003.198.12.1071	Diagnosis
Cervical Cancer Screening (QIP 2021)	pap_tests	Pap Test	2.16.840.1.113883.3.464.1003.108.12.1017	Labs
	hpv_tests	HPV Test	2.16.840.1.113883.3.464.1003.110.12.1059	Labs
	hysterectomies	Hysterectomy with No Residual Cervix	2.16.840.1.113883.3.464.1003.198.12.1014	Diagnosis
	congenital_absence_cervix_cases	QIP: Absence of Cervix	No eCQM. See Note #2	Diagnosis
Colorectal Cancer Screening (QIP 2021)	fecal_occult_blood_tests	Fecal Occult Blood Test (FOBT)	2.16.840.1.113883.3.464.1003.198.12.1011	Labs
	stool_dna_tests	FIT DNA	2.16.840.1.113883.3.464.1003.108.12.1039	Labs
	sigmoidoscopies	No applicable Value Set (see Note #1)		
	ct_colonographies	No applicable Value Set (see Note #1)		
	colonoscopies	No applicable Value Set (see Note #1)		
	colorectal_cancer_cases	Malignant Neoplasm of Colon (See Note #3)	2.16.840.1.113883.3.464.1003.108.12.1001	Diagnosis
	colectomies	No applicable Value Set (see Note #1)		
Diabetes: HbA1c Good Control ( $\leq 9\%$ ) (QIP 2021)	diabetes_cases	Diabetes	2.16.840.1.113883.3.464.1003.103.12.1001	Diagnosis
	a1c_labs	HbA1c Laboratory Test	2.16.840.1.113883.3.464.1003.198.12.1013	Labs
	No applicable Importer	QIP: Diabetes Exclusions	No eCQM. See Note #4	Diagnosis
Controlling High Blood Pressure (QIP 2021)	essential_hypertension_cases	Essential Hypertension	2.16.840.1.113883.3.464.1003.104.12.1011	Diagnosis
	blood_pressure_readings	No applicable Value Set (see Note #1)		
	end_stage_renal_disease_cases	End Stage Renal Disease	2.16.840.1.113883.3.526.3.353	Diagnosis
		Chronic Kidney Disease, Stage 5	2.16.840.1.113883.3.526.3.1002	Diagnosis
	dialysis_treatments	Dialysis Services (See Note #5)	2.16.840.1.113883.3.464.1003.109.12.1013	Procedures
		Vascular Access for Dialysis (See Note #4)	2.16.840.1.113883.3.464.1003.109.12.1011	Procedures
	renal_transplants	Kidney Transplant Recipient	2.16.840.1.113883.3.464.1003.109.12.1029	Diagnosis
	pregnancy_observations	Pregnancy Dx	2.16.840.1.113883.3.600.1.1623	Diagnosis

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Quality Measure or Report Name	Importer	Value Set Name (default eCQM, except where noted)	OID (eCQM identifier)	Value Set Type
Well-Child Visits in the First 15 Months of Life (QIP 2021)	well_child_interventions	QIP: Well-Care	No eCQM. See Note #6	Procedures and Diagnosis
Child and Adolescent Well-Care Visits (QIP 2021)	well_child_interventions	QIP: Well-Care	No eCQM. See Note #6	Procedures and Diagnosis
Childhood Immunization Status (QIP 2021)	dtap_immunizations	DTaP Vaccine	2.16.840.1.113883.3.464.1003.196.12.1214	Vaccines
	flu_immunizations	Influenza Vaccine	2.16.840.1.113883.3.464.1003.196.12.1218	Vaccines
	hep_a_immunizations	Hepatitis A Vaccine	2.16.840.1.113883.3.464.1003.196.12.1215	Vaccines
	hep_b_immunizations	Hepatitis B Vaccine	2.16.840.1.113883.3.464.1003.196.12.1216	Vaccines
	hi_b_four_dose_immunizations	HiB Vaccine (3 dose schedule)	2.16.840.1.113883.3.464.1003.110.12.1083	Vaccines
	hi_b_three_dose_immunizations	HiB Vaccine (4 dose schedule)	2.16.840.1.113883.3.464.1003.110.12.1085	Vaccines
	ipv_immunizations	Inactivated Polio Vaccine (IPV)	2.16.840.1.113883.3.464.1003.196.12.1219	Vaccines
	mmr_immunizations	Measles, Mumps and Rubella (MMR) Vaccine	2.16.840.1.113883.3.464.1003.196.12.1224	Vaccines
	pcv_immunizations	Pneumococcal Conjugate Vaccine	2.16.840.1.113883.3.464.1003.196.12.1221	Vaccines
	rv_double_dose_immunizations	Rotavirus Vaccine (2 dose schedule)	2.16.840.1.113883.3.464.1003.196.12.1222	Vaccines
	rv_triple_dose_immunizations	Rotavirus Vaccine (3 dose schedule)	2.16.840.1.113883.3.464.1003.196.12.1223	Vaccines
	vzv_immunizations	Varicella Zoster Vaccine (VZV)	2.16.840.1.113883.3.464.1003.196.12.1170	Vaccines
	chicken_pox_cases	Varicella Zoster	2.16.840.1.113883.3.464.1003.110.12.1039	Diagnosis
	encephalopathy_cases	Encephalopathy due to Childhood Vaccination	2.16.840.1.113883.3.464.1003.114.12.1007	Diagnosis
	hepatitis_a_cases	Hepatitis A	2.16.840.1.113883.3.464.1003.110.12.1024	Diagnosis
	hepatitis_b_cases	Hepatitis B	2.16.840.1.113883.3.464.1003.110.12.1025	Diagnosis
	measles_cases	Measles	2.16.840.1.113883.3.464.1003.110.12.1053	Diagnosis
	mumps_cases	Mumps	2.16.840.1.113883.3.464.1003.110.12.1032	Diagnosis
	rubella_cases	Rubella	2.16.840.1.113883.3.464.1003.110.12.1037	Diagnosis
	histiocytic_tissue_cancer_cases	Malignant Neoplasm of Lymphatic and Hematopoietic Tissue (See Note #7)	2.16.840.1.113883.3.464.1003.108.12.1009	Diagnosis
leukemia_cases	Malignant Neoplasm of Lymphatic and Hematopoietic Tissue	2.16.840.1.113883.3.464.1003.108.12.1009	Diagnosis	
lymphoreticular_tissue_cancer_cases	Malignant Neoplasm of Lymphatic and Hematopoietic Tissue	2.16.840.1.113883.3.464.1003.108.12.1009	Diagnosis	

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Quality Measure or Report Name	Importer	Value Set Name (default eCQM, except where noted)	OID (eCQM identifier)	Value Set Type
	multiple_myeloma_cases	Malignant Neoplasm of Lymphatic and Hematopoietic Tissue	2.16.840.1.113883.3.464.1003.108.12.1009	Diagnosis
	hiv_cases	HIV	2.16.840.1.113883.3.464.1003.120.12.1003	Diagnosis
	immunodeficiency_cases	Disorders of the Immune System	2.16.840.1.113883.3.464.1003.120.12.1001	Diagnosis
	No applicable Importer	Intussusception	2.16.840.1.113883.3.464.1003.199.12.1056	Diagnosis
	hep_a_antigen_labs	Anti Hepatitis A IgG Antigen Test	2.16.840.1.113883.3.464.1003.198.12.1033	Labs
	hep_b_antigen_labs	Anti Hepatitis B Virus Surface Ab	2.16.840.1.113883.3.464.1003.198.12.1073	Labs
	mmr_antigen_labs	Measles Antibody Test (IgG Antibody presence)	2.16.840.1.113883.3.464.1003.198.12.1060	Labs
		Measles Antibody Test (IgG Antibody Titer)	2.16.840.1.113883.3.464.1003.198.12.1059	Labs
		Mumps Antibody Test (IgG Antibody presence)	2.16.840.1.113883.3.464.1003.198.12.1062	Labs
		Mumps Antibody Test (IgG Antibody Titer)	2.16.840.1.113883.3.464.1003.198.12.1061	Labs
		Rubella Antibody Test (IgG Antibody presence)	2.16.840.1.113883.3.464.1003.198.12.1064	Labs
		Rubella Antibody Test (IgG Antibody Titer)	2.16.840.1.113883.3.464.1003.198.12.1063	Labs
	vzv_antigen_labs	Varicella Zoster Antibody Test (IgG Antibody Presence)	2.16.840.1.113883.3.464.1003.198.12.1067	Labs
		Varicella Zoster Antibody Test (IgG Antibody Titer)	2.16.840.1.113883.3.464.1003.198.12.1066	Labs
	baker_yeast_allergies	No applicable Value Set (see Note #1)		
	dtap_vaccine_allergies	No applicable Value Set (see Note #1)		
	flu_vaccine_allergies	No applicable Value Set (see Note #1)		
	hep_a_vaccine_allergies	No applicable Value Set (see Note #1)		
	hep_b_vaccine_allergies	No applicable Value Set (see Note #1)		
	hi_b_vaccine_allergies	No applicable Value Set (see Note #1)		
	ipv_vaccine_allergies	No applicable Value Set (see Note #1)		
	mmr_vaccine_allergies	No applicable Value Set (see Note #1)		
	neomycin_allergies	No applicable Value Set (see Note #1)		
	neomycin_allergies	No applicable Value Set (see Note #1)		
	pcv_vaccine_allergies	No applicable Value Set (see Note #1)		
	polymyxin_b_allergies	No applicable Value Set (see Note #1)		
	rv_vaccine_allergies	No applicable Value Set (see Note #1)		

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Quality Measure or Report Name	Importer	Value Set Name (default eCQM, except where noted)	OID (eCQM identifier)	Value Set Type
	streptomycin_allergies	No applicable Value Set (see Note #1)		
	vzv_vaccine_allergies	No applicable Value Set (see Note #1)		
Immunizations for Adolescents (QIP 2021)	mcv_immunizations	QIP: Meningococcal Vaccine Administered	No eCQM	Vaccines
	tdap_immunizations	QIP: Tdap Vaccine Administered	No eCQM	Vaccines
	hpv_immunizations	QIP: HPV Vaccine Administered	No eCQM	Vaccines
	mcv_vaccine_allergies	No applicable Value Set (see Note #1)		
	tdap_vaccine_allergies	No applicable Value Set (see Note #1)		
	hpv_vaccine_allergies	No applicable Value Set (see Note #1)		
	meningococcal_meningitis_antigen_labs	No applicable Value Set (see Note #1)		
	tetanus_antigen_labs	No applicable Value Set (see Note #1)		
	diphtheria_antigen_labs	No applicable Value Set (see Note #1)		
	pertussis_antigen_labs	No applicable Value Set (see Note #1)		
	hpv_antigen_labs	No applicable Value Set (see Note #1)		
	encephalopathy_cases	Encephalopathy due to Childhood Vaccination	2.16.840.1.113883.3.464.1003.114.12.1007	Diagnosis
Counseling for Nutrition for Children/Adolescents (QIP 2021)	nutrition_counselings	QIP: Nutrition Counseling (see Note #8)		Procedures and Diagnosis
Counseling for Physical Activity for Children/Adolescents (QIP 2021)	physical_activity_counselings	QIP: Physical Activity Counseling (see Note #9)		Diagnosis
Asthma Medication Ratio (QIP 2021)	asthma_cases	Asthma	2.16.840.1.113883.3.117.1.7.1.271	Diagnosis
		Persistent Asthma	2.16.840.1.113883.3.464.1003.102.12.1023	Diagnosis
	chronic_obstructive_pulmonary_disease_cases	COPD	2.16.840.1.113883.3.666.5.776	Diagnosis
		Obstructive Chronic Bronchitis	2.16.840.1.113883.3.464.1003.102.12.1024	Diagnosis
		Emphysema	2.16.840.1.113883.3.464.1003.102.12.1004	Diagnosis
	cystic_fibrosis_cases	Cystic Fibrosis	2.16.840.1.113883.3.464.1003.102.12.1002	Diagnosis
	acute_respiratory_failure_cases	Acute Respiratory Failure	2.16.840.1.113883.3.464.1003.102.12.1018	Diagnosis
fumes_exposure_cases	QIP: Chronic Respiratory Conditions Due To Fumes/ Vapors	No eCQM	Diagnosis	

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Quality Measure or Report Name	Importer	Value Set Name (default eCQM, except where noted)	OID (eCQM identifier)	Value Set Type
	asthma_medications	No applicable Value Set (see Note #1)		
Advanced Care Planning (QIP 2021)	advance_care_plannings	No applicable Value Set (see Note #1)		
Alcohol Misuse Screening and Counseling (QIP 2021)	No specific Importers			
Common	long_term_care_stays	Care Services in Long-Term Residential Facility	2.16.840.1.113883.3.464.1003.101.12.1014	Diagnosis
	hospice_care_interventions	No applicable Value Set (see Note #1)		
	palliative_care_cases	Palliative care encounter	2.16.840.1.113883.3.600.1.1575	Diagnosis
	frailty_cases	Frailty Diagnosis	2.16.840.1.113883.3.464.1003.113.12.1074	Diagnosis
		Frailty Symptom	2.16.840.1.113883.3.464.1003.113.12.1075	Diagnosis
		Frailty Encounter	2.16.840.1.113883.3.464.1003.101.12.1088	Procedures
	advanced_illness_cases	Advanced Illness	2.16.840.1.113883.3.464.1003.110.12.1082	Diagnosis
dementia_medications	Dementia Medications	2.16.840.1.113883.3.464.1003.196.12.1510	Medications	

### Notes

Note #1: "No applicable Value Set" means that either there is no Value Set at all, or the Value Set contains codes not applicable to the health center EHR.

Note #2: The QIP Value Set "Absence of Cervix" overlaps the eCQM Value Set "Hysterectomy with No Residual Cervix" but features one additional code that seems appropriate: [Q51.5] Agenesis and aplasia of cervix.

Note #3: This QIP Value Set "Colorectal Cancer" overlaps the eCQM Value Set "Malignant Neoplasm of Colon" but features these additional codes that seem appropriate:

- [Z85.038] Personal history of other malignant neoplasm of large intestine
- [Z85.048] Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
- [V10.05] Personal history of malignant neoplasm of large intestine
- [V10.06] Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

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Note #4: The QIP Value Set "Diabetes Exclusions" contains the codes used by the exclusion, but there is not an Importer for this in Relevant. Therefore, these codes are built into the measure SQL itself (this is an exception to the standard QIP QM design).

Note #5: The procedure codes for dialysis are very unlikely to be used in a health center. Therefore, the health centers may choose to not use the Value Sets directly.

Note #6: The same QIP Value Set for Well-Care visits can be used for the Under 15-month and the 3 to 17 years of age measures. Also note that the Value Set contains both procedure and diagnosis codes.

Note #7: The Value Set "Malignant Neoplasm of Lymphatic and Hematopoietic Tissue" contains all of the codes for the four related Importers. Note that these Importers are always referenced together in the Childhood Immunization Quality Measure.

Note #8: An eCQM Value Set for "Counseling for Nutrition" (OID = 2.16.840.1.113883.3.464.1003.195.12.1003) exists but does not contain any diagnosis codes. Therefore, the QIP Value Set is recommended along with any other standard codes or structured data that the health center uses.

Note #9: An eCQM Value Set for "Counseling for Physical Activity" (OID = 2.16.840.1.113883.3.464.1003.118.12.1035) exists but does not contain any procedure or diagnosis codes. Therefore, the QIP Value Set is recommended along with any other standard codes or structured data that the health center uses.