
Configuring the RCHC Relevant QIP ECDS Quality Measures



Serving Sonoma, Napa, Marin & Yolo Counties

Author: Ben Fouts, Informatics

Redwood Community Health Coalition

1310 Redwood Way, Petaluma, California 94954

support@rchc.net

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Introduction

Project Overview

Partnership Healthplan is moving towards a model where health centers securely submit detailed patient data, which is then combined with administrative and other data sources Partnership possesses to more accurately evaluate the HEDIS measures reported to the State of California. This is referred to as Electronic Medical Record Data Exchange (ECDS) and Partnership is beginning with a number of measures that are designated by HEDIS as electronic measures.

The data submission process is a pilot project in 2022, but it will be a requirement in 2023. Health centers that choose to participate in the 2022 ECDS project submit patient data to Partnership. Special Relevant reports have been designed by RCHC for this purpose¹. Regardless of participation status, RCHC is providing a set of Relevant Quality Measures that can be used to monitor progress based on data contained in the health center EHR.

There are eight HEDIS measures in the ECDS measure set. These are:

1. Breast Cancer Screening (already an established Quality Measure in Relevant)
2. Depression Screening and Follow-up (already an established Quality Measure in Relevant)
3. Prenatal Depression Screening and Follow-Up
4. Postpartum Depression Screening and Follow-Up
5. Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
6. Depression Remission or Response for Adolescents and Adults
7. Follow-Up Care for Children Prescribed ADHD Medication
8. Unhealthy Alcohol Use Screening and Follow-Up

Two of the above measures have more than one numerator and therefore have more than one Relevant Quality Measure. These are Depression Remission or Response for Adolescents and Adults (three separate Quality Measures) and Follow-Up Care for Children Prescribed ADHD Medication (two separate Quality Measures). The rest of the measures are represented by one Quality Measure each. There is a total of eleven ECDS-related Quality Measures in Relevant.

Some of the Quality Measures use standard Data Elements that have already been developed in Relevant. Other measures focus on completely new subject areas and will require new

¹ See the document “Configuring the RCHC Relevant QIP ECDS Reports” from RCHC

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Transformer/Data Element pairs. Health centers are also encouraged to establish appropriate workflows and documentation around these new subject areas, if these do not already exist. From a data perspective, it is also interesting to define a “baseline” level for new measures so that subsequent performance improvement can be easily recognized.

Supporting Documents

Most of the supporting documents reference the patient-level submission report portion of the project. Even though the patient-level submission reports will be used by Partnership to evaluate the measures, they cannot be used to define the denominators and numerators of the quality measures themselves. Nonetheless, documents for the patient-level submission report give some context to the overall project and describe certain aspects of the measures. Even if a health center is not participating in the 2022 data submission process, these documents might still be helpful. Furthermore, there is overlap exists in the Relevant data extraction processes between the RCHC Reports and Quality Measures.

There is a full description of available resources in the document “Configuring the RCHC Relevant QIP ECDS Reports.” This document, as well as the related webinar slides and recordings, are available RCHC website page for Data Governance and Analytics under the heading Partnership ECDS Reporting ². Notably, in this section is a webinar that focuses on the ECDS Quality Measures called “New ECDS Measures: Focus on Relevant Quality Measures” (August 9, 2022). This is the main presentation that discusses the ECDS Quality Measures and is the companion presentation for the ECDS QM Set Configuration document.

Partnership Patients

The Quality Measures have a similar design as the QIP Quality Measure set developed by RCHC in 2021. The default SQL code evaluates ALL patients who qualify for the denominator. Health centers can decide to have an individual measure focus on all patients, focus only on current Partnership patients, or have two versions of the measure to track both populations. This approach was previously recommended for the other QIP reports, so it makes sense to use the same approach for all Partnership measures as a unified set. Note that some additional technical considerations are necessary to configure the Quality Reports to display only Partnership patients.

² <https://www.rchc.net/population-health/data-analytics-and-governance/#toggle-id-2>

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To focus on the Partnership patient population in a Quality Measure, there must be some way to define Partnership patients who are active in a particular month. The enrollment list changes month-to-month and so the Quality Measure denominator should change month-to-month as well. Therefore, health centers that download Partnership patients monthly from eReports (or have another system in place) and integrate it into Relevant have the option to restrict their QIP/ECDS Quality Measures to partnership patients³.

Note that simply restricting patients by their current primary insurance (equal to Partnership Managed Care) will not yield accurate historical data needed for the standard monthly trend line featured by the Quality Measure.

General Comments on the SQL Code Examples

In the rest of this document, there are profiles of the Quality Measures and each section has a definition of the measure and a bit of background information. Some of the Quality Measures require new Transformer/Data Element pairs, and there are suggestions for setting them up, including sample SQL code. The references to SQL code for Transformers contained in this document is for health centers using Relevant and the eCW Electronic Health Record. NextGen SQL code will be developed separately, although the approach and many of the ideas are the same.

Note that the sample SQL code for Transformers and Data Elements can be modified to suit the “best practices” at the health center for extracting data. The recommendation for all Transformers/Data Elements that pull standard data is to use the applicable Value Sets that define the codes⁴ needed. Appendix A contains a list of eCQM and HEDIS Value Sets that are applicable to the ECDS measure set.

Sample SQL code is displayed only for NEW Transformers and Data Elements. Some of the measures use Data Elements that should already exist in the system. See Appendix B for completely new ECDS Quality Measures, as well as new Transformers and Data Elements that need to be added, configured, and validated in the health center instances of Relevant.

Some of the ECDS Quality Measures might show zero patients in the numerator or denominator until the associated Transformers/Data Elements are configured and enabled.

³ There is not a standard or recommended SQL code for achieving this as of the writing of these instructions

⁴ Such as procedure (CPT) and diagnosis (ICD) codes

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As mentioned previously, two Quality Measures are currently present in Relevant and have the same definition as the ECDS measure. These are Depression Screening and Follow up and Breast Cancer Screening. They will not be discussed any further below.

Health center programmers are encouraged to send feedback on the SQL code (comments on the approach, logic, expressions, etc.) to Ben Fouts (bfouts@rchc.net) so that the code can be improved during the validation process. Changes will be discussed on the RCHC Slack Population Health channel (#relevant_users) and the report SQL code on the RCHC Instance updated, if necessary. Therefore, Quality Measures on the RCHC Instance will always be the best and most updated source of SQL code.

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Prenatal Depression Screening and Follow-Up (Aligns With HEDIS Measure PND)

This measure was authored by Relevant because it also belongs to the MCAS (State of California Medicaid) Measure Set.

Definition: The percentage of deliveries in which patients were screened for clinical depression with a standardized instrument while pregnant and, if screened positive, received follow-up care within 30 days.

This measure is similar in design to the familiar Depression Screening and Follow-Up measure (Relevant Quality Measure “Preventive Care and Screening: Screening for Depression and Follow-Up Plan (UDS 2022 Table 6B)”). The difference is that this measure is focused on the prenatal patient population.

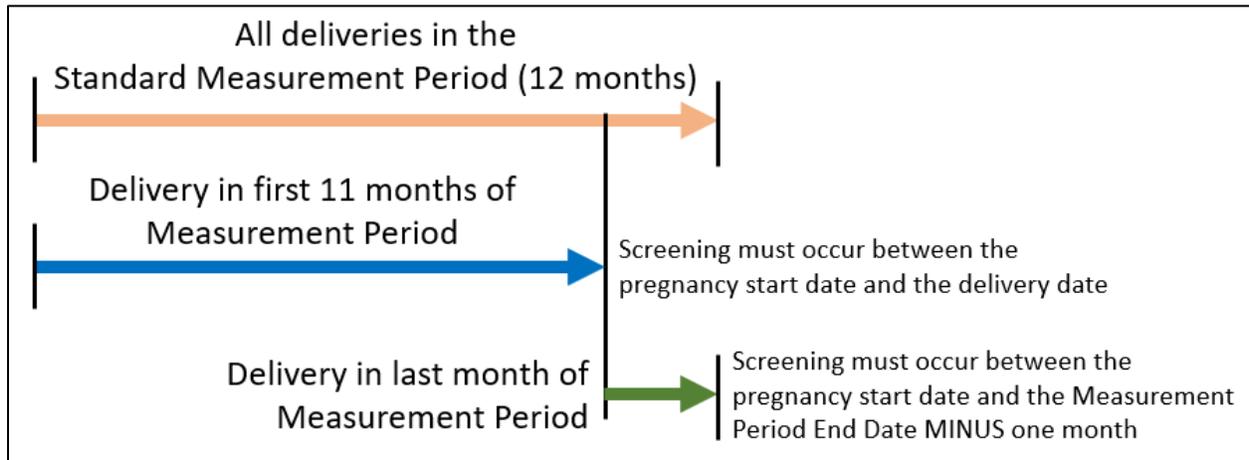
All patients with a documented delivery date within the Measurement Period are considered for the denominator.

Note that the definition of a “prenatal patient” depends on when the patient delivered and all calculations are based on that date. In Relevant, this date appears in the field pregnancy_deliveries.delivered_on. It is assumed that the pregnancy_deliveries Data Element has already been established and the delivered_on field thoroughly validated. It is vital that health centers continue their data quality efforts to ensure that delivery dates are being gathered and entered into the EHR for all patients who deliver, when that information is available. This is true for other reporting entities as well, including the UDS.

To be considered for the measure, prenatal depression screens must occur while the patient is pregnant. For patients who delivered in the last month of the Measurement Period, screens must occur before 30 days prior to the end of the Measurement Period in order to give enough time for follow-up (maximum of 30 days).

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Below is a logic scheme for the screening portion of the measure.



If the patient was not screened for depression, the patient does not enter the numerator. If at least one depression screen is documented and none are positive, the patient is counted in the numerator. Otherwise, the first positive screen date is considered for the second part of the numerator and a follow-up must occur within 30 days.

Whereas some of the other depression measures in the ECDS report set only focus on the PHQ-9 score, the prenatal screening and follow up measure allows for other standardized screening instruments⁵. The most common of these alternate screens is the Edinburgh Postnatal Depression Scale (EPDS).

Therefore, the health center should identify all standardized depression screening tools in-use⁶. These tools need to have a score and/or result entered into Structured Data. A new Transformer/Data Element pair has been developed for the Edinburgh Scale.

On the next page is a discussion about how to extract data for the Edinburgh Depression Screen Transformer/Data Element pair. This is only applicable if your health center uses this instrument. Note that the Category ID (catid), Item ID (itemid) and Detail ID (detailid) are unique to the health center. The

⁵ The partnership specifications document contains a table that has all the names of the instruments approved by HEDIS and the minimum score that should be interpreted as a positive result. The health center should make sure that their interpretation of a raw score aligned with the standard interpretation of a raw score.

⁶ This may be done in consultation with clinical staff at the health center. Furthermore, eCW health centers can use the validation report "RCHC List All Structured Data Items." See the presentation New ECDS Measures: Focus on Reports (July 19, 2022) for an example of how to use the report for the depression-related Measures.

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Data Element named “Edinburgh Depression Screens” should already exist in Relevant but might need to be mapped.

NEW Transformer/Data Element Pair for Edinburgh Depression Screens

Configure only if your health center uses the Edinburgh Depression Screen. Note that the ID numbers for catid, itemid, and detailed will be unique at each health center.

Transformer: Build relevant_edinburgh_screens

Description: Creates a list of Edinburgh screens entered into structured data

The health center can customize the name of this Transformer to conform to internal norms.

Below is an example of SQL code that can be used to extract Edinburgh Depression Screen data from structured HPI (at a health center using eCW). The ID codes for the category, item and detail are specific for the “score” of the screen at the health center. In this example, the Edinburgh screen score exists in HPI but there may be Edinburgh Depression Screens entered in more than one table in structured data (including OB tables), or in more than one category. From any location, an actual score must be entered into a field (not just a note or date that the screen was performed). In the code below, the screen score is displayed in the field “score” and the result is interpreted with a formula in the field “result.” The health center may also have a structured data field for the screen result, which can be used instead.

```

DROP TABLE IF EXISTS relevant_edinburgh_screens;
CREATE TABLE relevant_edinburgh_screens AS
SELECT DISTINCT
  enc.patientid      AS patient_id,
  enc.encounterid    AS visit_id,
  enc.date :: DATE   AS performed_on,
  structhpi.value :: INT AS score,
  CASE WHEN structhpi.value :: INT >= 10 THEN TRUE
  ELSE FALSE END    AS result
FROM enc
  INNER JOIN structhpi ON structhpi.encounterid = enc.encounterid
  AND structhpi.catid = 170663
  AND structhpi.itemid = 10575
  AND structhpi.detailid = 1549 --Use a unique combination of ID codes to identify the Edinburgh
screen score in structured data
WHERE enc.deleteflag = 0
  AND enc.status = 'CHK'
  AND structhpi.value ~ '^\\d+$'
```

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There is, of course, flexibility with how this Transformer is designed. Feel free to use the best practices or standardized practices for programming that may exist at your health center. The main feature of this Transformer is that it displays the date, score and result for each individual Edinburgh Depression Screen completed.

Data Element: Edinburgh Depression Screens

```
SELECT DISTINCT
  patient_id,
  performed_on,
  score,
  result
FROM relevant_edinburgh_screens
```

The field “result” is BOOLEAN. It should equal TRUE when the depression screen result has a positive finding and FALSE if the screen has a negative finding. See the Partnership specifications for the standard thresholds.

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Postpartum Depression Screening and Follow-Up (Aligns With HEDIS Measure PDS)

This measure was authored by Relevant because it also belongs to the MCAS (State of California Medicaid) Measure Set.

Definition: The percentage of deliveries in which patients were screened for clinical depression with a standardized instrument during the postpartum period (i.e., between 7 and 84 days following the date of delivery) and, if screened positive, received follow-up care within 30 days.

The approach and design of this measure is very similar to the previous measure for prenatal patients. The difference is that this measure focuses on the postpartum period while the previous measure focuses on the prenatal period. In both cases, the Edinburgh Depression Screen is acceptable for the patient population and should be added to the data model if it is being used at the health center.

See the notes for the measure “Prenatal Depression Screening and Follow-Up” above, including the discussion of the new Transformer/Data Element Pair for Edinburgh Depression Screens.

Other Measure Considerations and Background

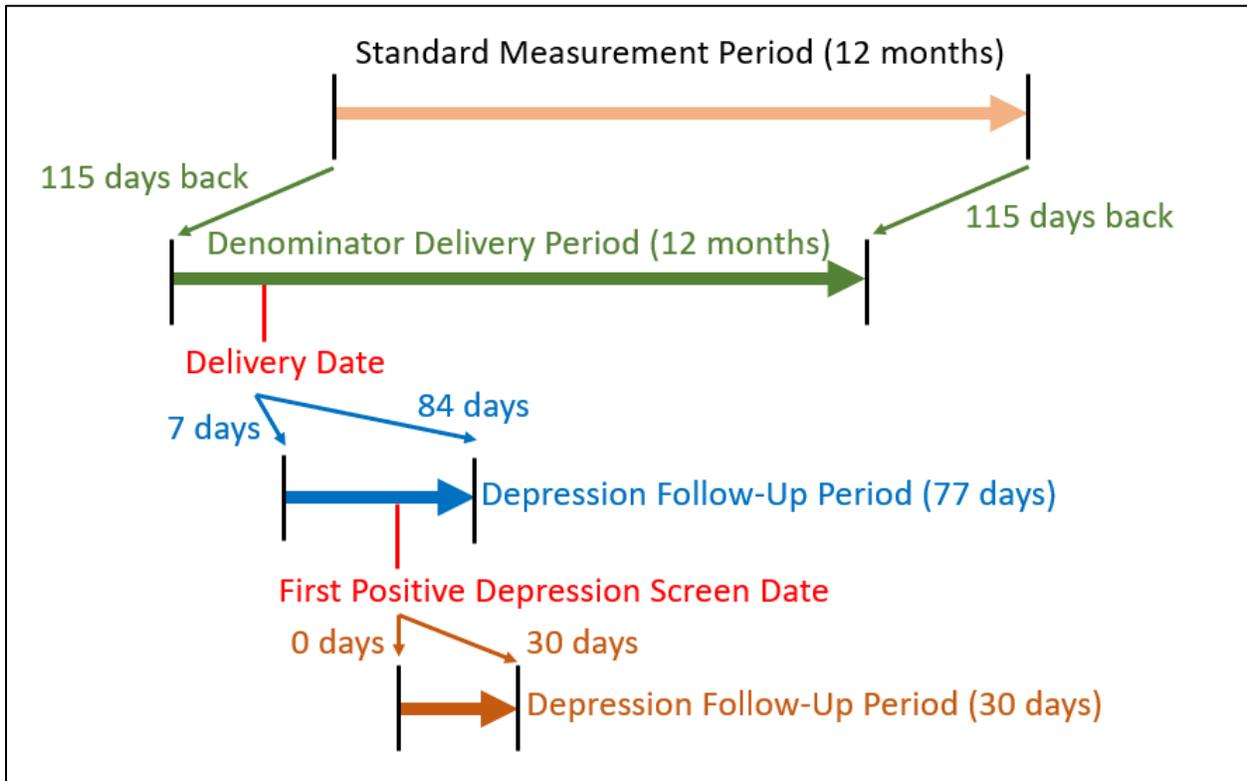
All patients with a documented delivery 115 days before the start of the Measurement Period to 115 days before the end of the Measurement Period are considered for the denominator.

Note that the definition of a prenatal patient depends on when the patient delivered, and all calculations are based on that date. In Relevant, this date appears in the field pregnancy_deliveries.delivered_on. It is assumed that the pregnancy_deliveries Data Element has already been established and the delivered_on field thoroughly validated. It is vital that health centers continue their data quality efforts to ensure that delivery dates are being gathered and entered into the EHR all patients who deliver, when that information is available. This is true for other reporting entities as well, including the UDS.

To be considered for the measure, postpartum depression screens must occur between 7 and 84 days following the date of delivery. If at least one screen is documented and none are positive, the patient is counted in the numerator. The first positive screen in this period is considered for the second part of the numerator and a follow-up must occur within 30 days.

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Below is a logic model with illustrative delivery and first positive screen dates.



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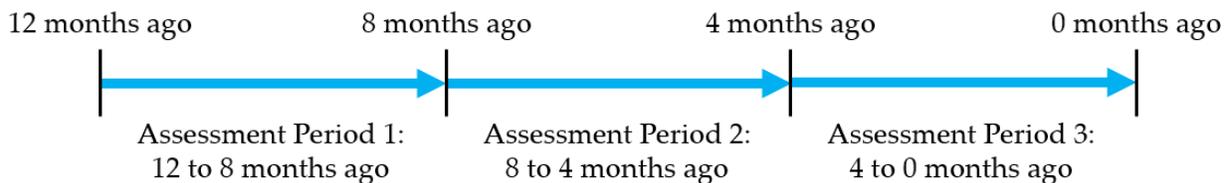
Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (Aligns With HEDIS Measure DMS)

Definition: The percentage of patients 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.

The HEDIS measure itself is based on a full calendar year and features three assessment periods reported separately: January 1–April 30 (Assessment Period 1), May 1–August 31 (Assessment Period 2) and September 1–December 31 (Assessment Period 3). This approach, however, does not fit into the design of a standard Relevant Quality Measure with a year-long Measurement Period that rolls forward month-to-month.

Therefore, a decision was made to not break the measure into three separate Quality Measures looking back at four-month periods at various distances in the past. Instead, the Quality Measure combines the three Assessment Periods. If a patient has a visit in any particular assessment period, the measure considers if a PHQ-9 was performed in the same Assessment Period. Assessment Periods are evaluated separately but results added together. In other words, to be in the overall numerator, a denominator patient must have a PHQ-9 in all Assessment Periods with at least one visit.

The Assessment Periods relative to the rolling Measurement Period are defined as follows:



The exclusions for this report are patients with bipolar disorder, personality disorder, psychotic disorder, pervasive developmental disorder (all before the end of the Measurement Period) or using hospice services during the measurement period.

No new Transformers or Data Elements are required for this measure

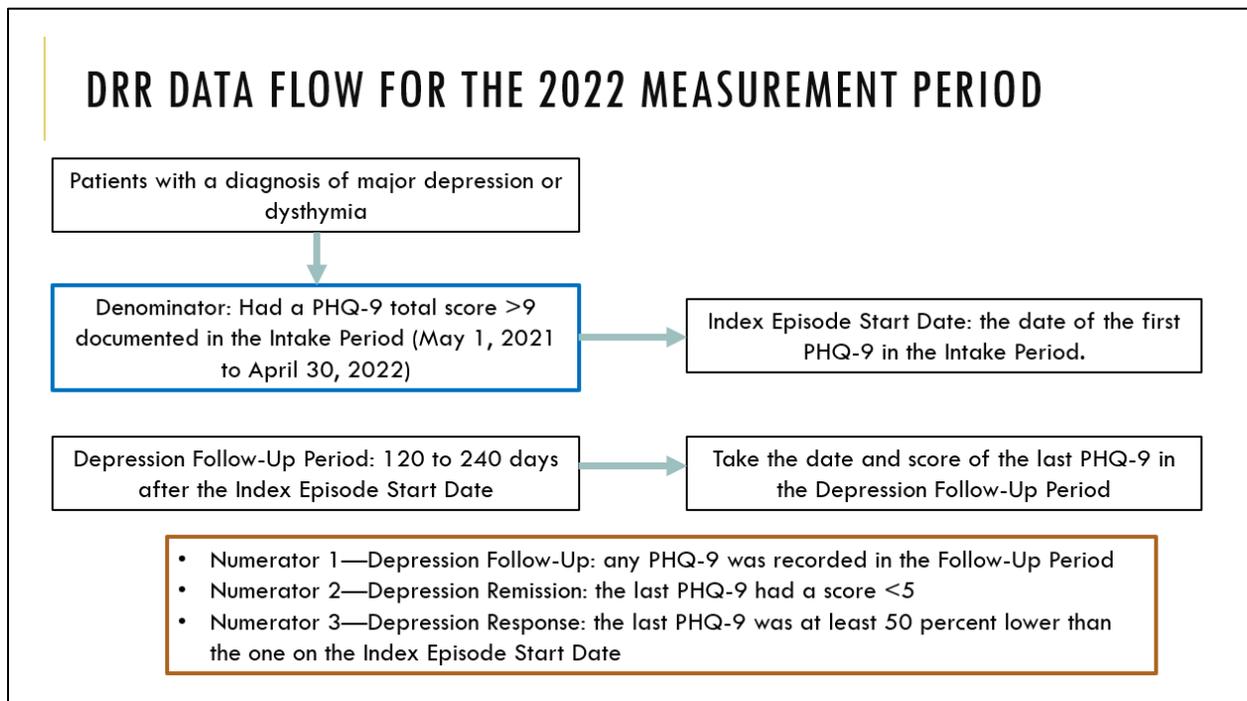
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Depression Remission or Response for Adolescents and Adults (Aligns With HEDIS Measure DRR)

This measure has a different definition than the UDS Measure “Depression Remission at Twelve Months” (CMS159v10)

Definition: The percentage of patients 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.

A data flow example based on the 2022 Measurement Period is illustrated below.



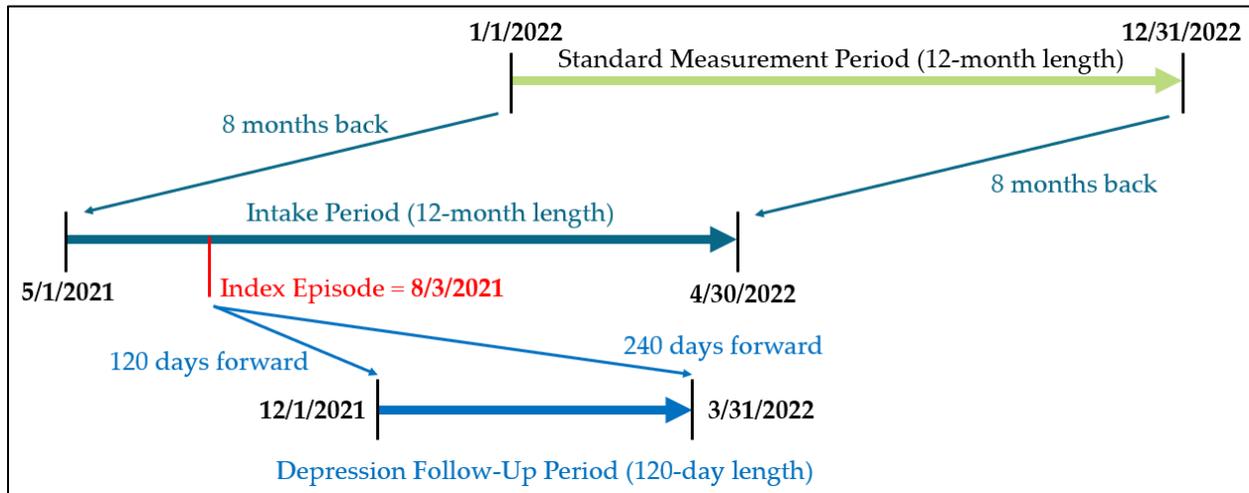
This measure features a Measurement Period, Intake Period and Follow-Up Period, which are all relative to each other. The definitions are:

- Measurement Period: The standard year-long measurement period used in other Relevant Quality Measures
- Intake Period: Eight months prior to start of Measurement Period, to eight months prior to end of Measurement Period

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- Index Episode Start Date: The earliest date during the Intake Period where the patient had a diagnosis of major depression or dysthymia and a PHQ-9 total score >9 documented
- Depression Follow-Up Period: Between 120 and 240 days after the date of the Index Episode Start Date
- Follow-up PHQ-9 Score: The score of the last PHQ-9 in the Depression Follow-Up Period

Below is another way of understanding the measure, using a logic model. The Index Episode date (8/23/2021) is only an example and this date can actually occur at any time during in the Intake Period.



There are three separate Relevant Quality Measures for the three numerators that use the same denominator. They are:

1. **Follow-Up PHQ-9.** The percentage of denominator patients who have a follow-up PHQ-9 score documented during the Depression Follow-Up Period. *Quality Measure: Depression Remission or Response for Adolescents and Adults: Follow-Up PHQ-9 (Aligns With 2022 HEDIS Measure DRR)*
2. **Depression Response.** The percentage of denominator patients who showed response during the Depression Follow-Up Period. This is defined as the most recent PHQ-9 during the Follow-Up Period having a score at least 50% lower than the score of the Index Episode PHQ-9. *Quality Measure: Depression Remission or Response for Adolescents and Adults: Depression Response (Aligns With 2022 HEDIS Measure DRR)*
3. **Depression Remission.** The percentage of denominator patients who achieved remission during the Depression Follow-Up Period. This is defined as the most recent PHQ-9 during the Follow-Up Period having a score of less than 5. *Quality Measure: Depression Remission or Response for Adolescents and Adults: Depression Remission (Aligns With 2022 HEDIS Measure DRR)*

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The exclusions for this report are patients with bipolar disorder, personality disorder, psychotic disorder, pervasive developmental disorder (all before the end of the Measurement Period) or using hospice services during the measurement period.

No new Transformers or Data Elements are required for this measure.

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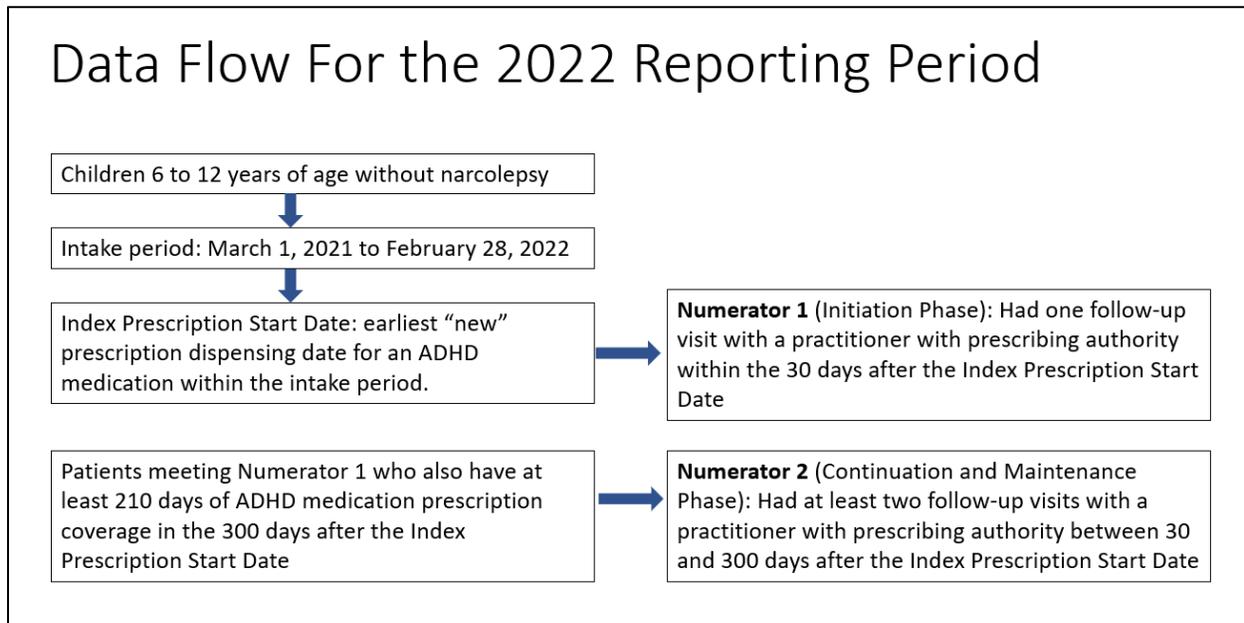
Follow-Up Care for Children Prescribed ADHD Medication (Aligns With HEDIS Measure ADD)

Definition: The percentage of children (6 to 12 years of age) with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

Two rates are calculated on two separate Quality Measures:

1. The percentage of denominator patients who had one follow-up visit within 30 days of when the first ADHD medication was dispensed. *Quality Measure: Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase (Aligns With 2022 HEDIS Measure ADD)*
2. For denominator patients who remained on the medication for 210 days, the percentage of patients who were in the first numerator **and** had at least two additional visits between 30 and 300 days of when the first ADHD medication was dispensed. *Quality Measure: Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase (Aligns With 2022 HEDIS Measure ADD)*

Below is the data flow for the measure using the 2022 reporting period as an example:

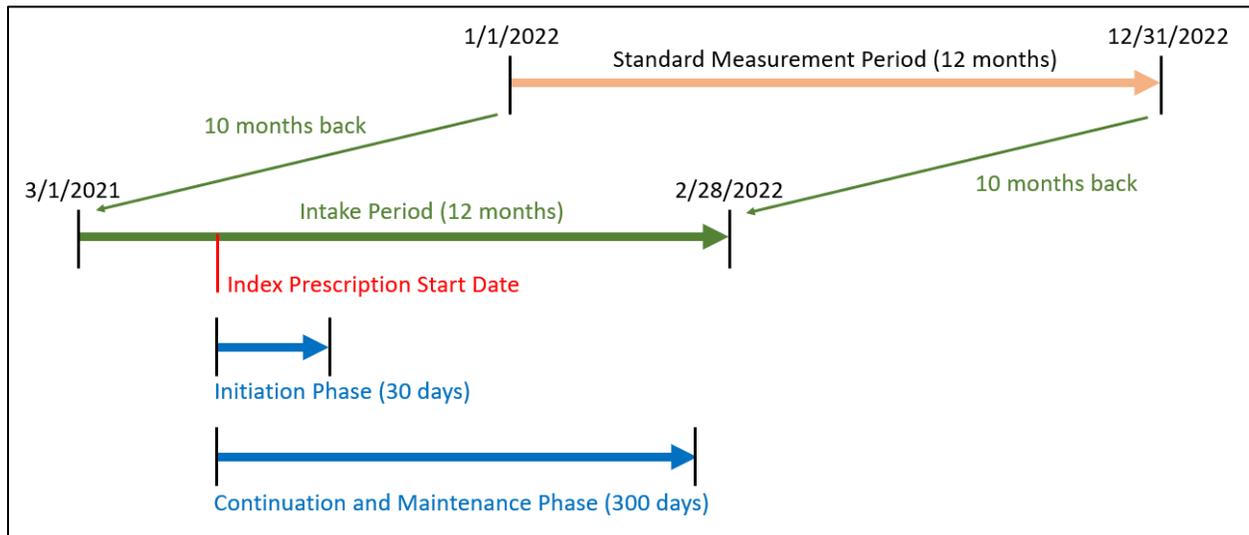


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This measure features a Measurement Period and an Intake Period, which are relative to each other. The definitions and a logic model example based on the 2022 Measurement Period are featured below.

- Measurement Period: The standard year-long measurement period used in other Relevant Quality Measures
- Intake Period: Ten months prior to start of Measurement Period, to ten months prior to end of Measurement Period
- Index Prescription Start Date: The earliest date for a new ADHD medication during the Intake Period
- Initiation Phase: Between the Index Prescription Start Date and 30 days after the Index Prescription Start Date
- Continuation and Maintenance Phase: Between the Index Prescription Start Date and 300 days after the Index Prescription Start Date
- Medication Coverage: Patients who remained on the medication for at least 210 days between the Index Prescription Start Date and 300 days after the Index Prescription Start Date

Below is another way of understanding the measure, using a logic model for the 2022 calendar year Measurement Period. The Index Prescription Start Date placement is only an example and this date can actually occur at any time during in the Intake Period.



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There are two separate Relevant Quality Measures for the two phases and each has a different denominator.

Initiation Phase

- Quality Measure Name: Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase (Aligns With 2022 HEDIS Measure ADD)
- Denominator 1: Patients 6 to 12 years of age with a new attention-deficit/hyperactivity disorder (ADHD) medication newly prescribed within the Initiation Phase.
- Numerator 1: Denominator patients who had one follow-up visit within 30 days of the Index Prescription Start Date.

A follow-up visit for Numerator 1 must be with a UDS provider with prescribing authority. The Quality Measure relies on Relevant Staff Member Types (these are configured by the health center). The Staff Member Types are Family Physicians, General Practitioners, Internists, Pediatricians, Other Specialty Physicians, Psychiatrists, Obstetrician/Gynecologists, Certified Nurse Midwives, Nurse Practitioners and Physician Assistants.

Continuation and Maintenance Phase

- Quality Measure Name: Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase (Aligns With 2022 HEDIS Measure ADD)
- Denominator 2: The definition of Denominator 1 **plus** patients who remained on the ADHD medication for at least 210 days between the Index Prescription Start Date and 300 days after the Index Prescription Start Date.
- Numerator 2: Denominator patients who were in Numerator 1 **plus** two additional follow-up visits with any practitioner between 31 and 300 days of the Index Prescription Start Date.

A follow-up visit for Numerator 2 must be with a medical or behavioral health UDS provider (i.e., one who exercises independent professional judgment). These include the Relevant Staff Member Types for Numerator 1 **plus** Licensed Clinical Psychologists, Licensed Clinical Social Workers and Other Licensed Mental Health Providers.

The exclusions are for narcolepsy or hospice services. No new Transformers or Data Elements are needed for the exclusions.

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NEW Transformer/Data Element Pair for ADHD Prescriptions

This Transformer/Data Element pair is different than other medication-related pairs in Relevant. We are interested in knowing each time the patient had a prescription for ADHD medications and how long the prescription lasted, in days (i.e., the “duration”). In contrast, other medication Transformer/Data Element pairs in Relevant normally display start dates and end dates for medications simply to allow a Quality Measure to calculate if the patient was using the medication during a particular period. Therefore, more detail and a different approach are needed for the ADHD medications used in this measure.

RCHC health centers may have different approaches to identifying medications and whether a prescription was generated ⁷. Thus, there is flexibility in the design of the Transformer, but in any case, the health center should always validate the data.

The default sample code below joins a Value Set defining ADHD medications (through Rx Norm codes) to the table relevant_medications. To follow this electronic procedure, the health center will need to have an enabled and validated relevant_medications Transformer that displays the RxNorm code of the medication. Furthermore, it is recommended that the unduplicated list of medications produced by the Transformer be verified with a clinical practitioner.

Nonetheless, other approaches to identifying ADHD medications may exist. Health centers should use their own standard and validated method to identify medications. If the health center has established an ADHD medication RxGroup (or if the health center chooses to establish one), then it can alternately be used. Note that the RxGroup will need to be managed, like other medication groups. The term “managed” means that the list is “clean” (no missing medications, no non-related medications) and that new medications from updated compendiums are continually added throughout the year. ADHD medications can also be identified by medication name. However, these methods may not be as practical as using the standard Value Set.

Below is some sample SQL code that you may consider for the design on the ADHD medication Transformer/Data Element pair. Important: See the section “Additional Considerations” after the SQL example.

⁷ If there is not an electronic method to verify if the patient actually picked up the medication, the prescription record can be used and assumed to be what the patient actually consumed.

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Transformer: Build relevant_adhd_prescriptions

Description: Lists individual visits where an ADHD medication is likely prescribed

The health center can customize the name of this Transformer to conform to internal norms.

```

DROP TABLE IF EXISTS relevant_adhd_prescriptions;
CREATE TABLE relevant_adhd_prescriptions AS
SELECT DISTINCT
  patient_id,
  started_on AS prescribed_on,
  CASE WHEN duration ILIKE '%day%' OR duration ILIKE '%d'
    THEN SUBSTRING(duration FROM '\d+') :: INT
    WHEN duration ILIKE '%week%' OR duration ILIKE '%wk%'
    THEN SUBSTRING(duration FROM '\d+') :: INT * 7 :: INT
    WHEN duration ILIKE '%month%' OR duration ILIKE '%mo%'
    THEN SUBSTRING(duration FROM '\d+') :: INT * 30 :: INT
    WHEN duration ~ '^d{1,3}$'
    THEN SUBSTRING(duration FROM '\d+') :: INT
    ELSE 0 :: INT END AS duration_days,
  medication AS medication_name,
  relevant_medications.rxnorm_code
FROM relevant_medications
  INNER JOIN oldrxmain ON oldrxmain.oidrxid = relevant_medications.id
  INNER JOIN cqm_value_set_codes ON cqm_value_set_codes.code_value = relevant_medications.rxnorm_code
WHERE value_set_oid = '2.16.840.1.113883.3.464.1003.196.12.1171'
  AND latest IS TRUE
  AND oldrxmain.doctorsflag IN(1,5);

```

Data Element: ADHD Prescriptions

```

SELECT
  patient_id,
  prescribed_on,
  duration_days,
  medication_name,
  rxnorm_code
FROM relevant_adhd_prescriptions

```

In the end, the Data Element should show one prescription for one ADHD medication from one visit date for one patient.

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Additional Considerations

The ADHD medications Transformer/Data Element pair for this measure is crucial. The central idea behind the measure is to identify patients who are newly prescribed ADHD medications and then track them over time if they remain on the medications⁸. Therefore, two important pieces of information come from the Transformer/Data Element pair. First, when did the patient begin using any ADHD medication (i.e., the Index Prescription Start Date)? Second, what was the total number of days the patient was using the medication in the 300 days after beginning ADHD medication (i.e., how many days of medication were taken during the Continuation and Maintenance Phase)? To calculate these, it is important to carefully select the data and transform it, if necessary.

First of all, it is a good idea to focus on prescriptions given to the patient. However, this information is not always displayed on the Transformer relevant_medications or the underlying eCW table oldrxmain. Note that a patient might be seen at the health center and have medications checked, resulting in an eCW record of the ADHD medication with the flag “Taking / Brought Forward” and a completed Duration field even though no new medications were dispensed. Including all records with the eCW flag “Taking / Brought Forward” by default would tend to double-count (or triple-count, etc. depending on the flags chosen during a single visit). This can be compounded depending how many visits occur between prescriptions where the medications are checked.

If your health center has a standard way of identifying actual prescriptions, that should be built into the Transformer code. The sample code above has limited the eCW Doctor’s Flag to the options of Start and Refill⁹. These can be narrowed or expanded, depending on which options the health center is confident that a prescription is usually created. In the example approach, it made sense that a prescription is created when a patient Starts a medication or has a Refill. Does this also occur when Continue, Increase, Decrease, or Change is entered as the flag at your health center?

Second, the health center should examine the data contained in the medication Duration field so see if a transformation is needed so that the number of days is always displayed. The sample SQL above contains a transformation (using a CASE WHEN expression) in the column duration_days because some

⁸ The HEDIS specification references the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter for the Assessment and Treatment of Children and Adolescents with ADHD: “Patients should be assessed periodically to determine whether there is continued need for treatment or if symptoms have remitted.”

⁹ This is done in the last line of the WHERE statement: oldrxmain.doctorsflag IN(1,5). For reference, there is an RCHC Validation Report named “RCHC List All Medication Flags” that displays all of the Doctor’s Flags used by a health center with eCW. Other options include Continue, Increase, Decrease, and Change, but these might not indicate that a prescription was created at the visit

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of the data in the Duration field appears to be in weeks or months. The column duration_days must display an **integer** representing the number of **days** the prescription as written for.

Health centers should check the raw text in the Duration field for ADHD medications and verify whether days, weeks and months are being entered. The integer portion of the text entry should not be simply extracted by default and assumed to be “days.”

To help with this investigation, below is some sample SQL that can be used to test the translation from the text Duration field to the duration_days field. Like the sample SQL code for the Transformer, it is based on relevant_medications. However, you can pull the medication data (with the Duration field) using any standard method instead. The code in the column days_supply translates the duration text from column duration_raw. The translation uses the ILIKE expression and pattern-matching Regex (Regular Expressions) in PostgreSQL. However, depending on the text that is entered at your health center, you may need to modify the expressions.

The basic idea is to scan across the rows of the output and compare the column duration_raw (the original text) to the column days_supply (the interpretation). If the interpretation is not correct, the CASE WHEN statement needs to be adjusted. Once the days_supply column is completely correct, the CASE WHEN statement can replace the default statement in the Transformer.

```

SELECT
  duration_raw,
  days_supply,
  COUNT(*) AS record_count
FROM(SELECT DISTINCT
  patient_id,
  started_on AS prescribed_on,
  duration AS duration_raw,
  CASE WHEN duration ILIKE '%day%' OR duration ILIKE '%d'
    THEN SUBSTRING(duration FROM '\d+') :: INT
  WHEN duration ILIKE '%week%' OR duration ILIKE '%wk%'
    THEN SUBSTRING(duration FROM '\d+') :: INT * 7 :: INT
  WHEN duration ILIKE '%month%' OR duration ILIKE '%mo%'
    THEN SUBSTRING(duration FROM '\d+') :: INT * 30 :: INT
  WHEN duration ~ '^d{1,3}$'
    THEN SUBSTRING(duration FROM '\d+') :: INT
  ELSE 0 :: INT END AS days_supply
FROM relevant_medications
INNER JOIN cqmq_value_set_codes ON cqmq_value_set_codes.code_value = relevant_medications.rxnorm_code
WHERE value_set_oid = '2.16.840.1.113883.3.464.1003.196.12.1171'

```

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AND latest IS TRUE) AS raw_data
GROUP BY duration_raw, days_supply
ORDER BY duration_raw, days_supply

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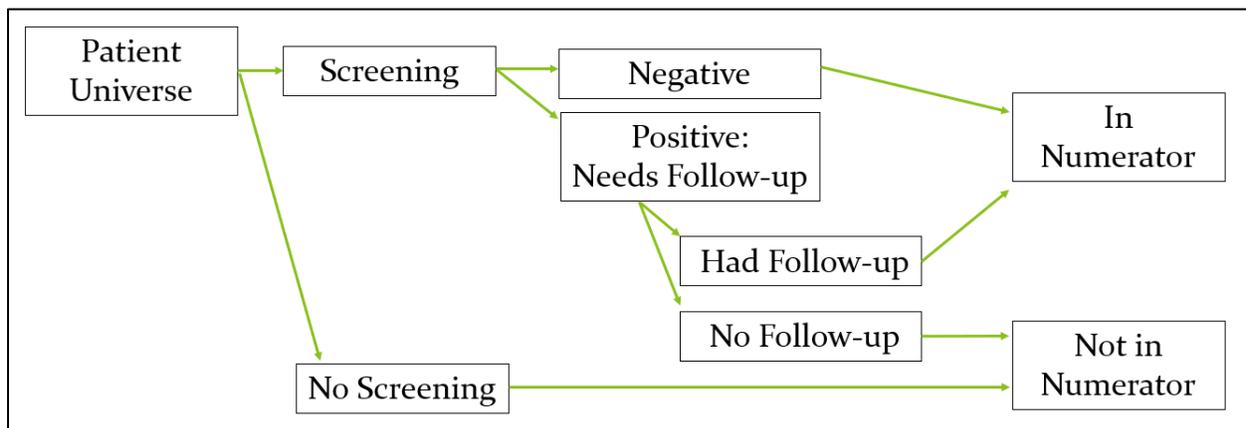
Unhealthy Alcohol Use Screening and Follow-Up (Aligns With HEDIS Measure ASF)

Definition: The percentage of patients 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care.

Similar to the approach by the UDS Preventive Care and Screening measures, this measure has two components evaluated by one Quality Measure. The components are:

1. Unhealthy Alcohol Use Screening. All denominator patients need to be screened for unhealthy alcohol use annually
2. Alcohol Counseling or Other Follow-up Care. Patients who screen positive for unhealthy alcohol use need to have brief counseling or other follow-up care within 60 days.

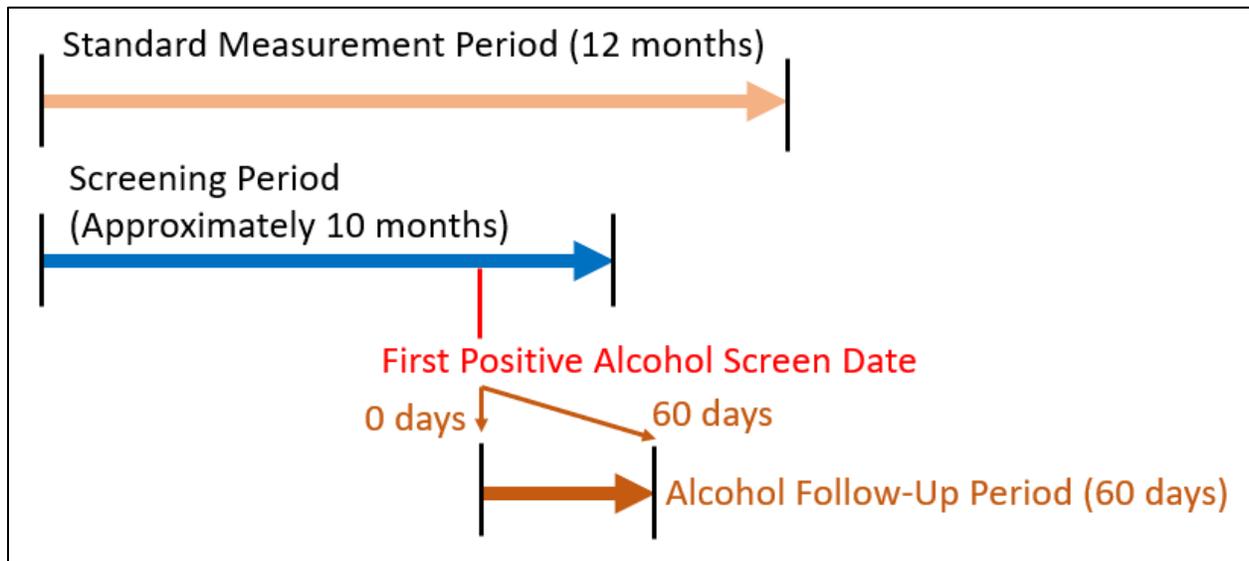
Below is an illustration of a data flow showing how patients are eligible for the numerator of the measure. This kind of flow is generally applicable to all Preventive Care and Screening measures.



The Unhealthy Alcohol Use Screening and Follow-Up measure permits up to 60 days for the follow-up to occur after the first positive alcohol screen in the Measurement Period. Therefore, to allow enough time for follow-up, only screenings between the Measurement Period Start Date and 60 days before the Measurement Period End Date are considered by the measure.

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Below is a diagram with an example of these overlapping measurement, screening and follow-up periods. The First Positive Alcohol Screen Date is shown at a particular point in the diagram, but it can actually occur any time in the Screening Period.



The 60-day follow-up period is defined by the specification of the HEDIS measure. Because it is not exactly two-months long, the screening period may not end squarely on the last day of a month when the Measurement Period does not end exactly on December 31.

Note that denominator patients must have at least one medical visit in the Screening Period (between the Measurement Period Start Date and 60 days before the Measurement Period End Date). This ensures that all patients in the denominator have the opportunity to be screened for the measure. This differs from most other Quality Measures that take at least one medical visit in the entire measurement period.

Preparation for Establishing this Quality Measure in Relevant

The first step is to identify any **alcohol screening instruments** used at the health center and where the data resides (most commonly somewhere in Structured Data¹⁰). Since this is a completely new measure, a formal procedure, efficient workflow and staff training may need to be established according to health

¹⁰ This should be done in consultation with clinical staff at the health center.

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center policy. In any case, establishing a Quality Measure to track alcohol screening and follow-up is an opportunity to solidify an approach, including what data is entered where in the EHR and by whom. Interpretation of alcohol screening instruments should mirror the national standards that appear in the Partnership Specifications for this measure.

There are three alcohol screening instruments that are approved for this measure. These are:

1. AUDIT-C
2. AUDIT
3. Single question alcohol screen

The single question alcohol screen must adhere to specific language or otherwise be approved by Partnership. The Partnership specifications document discusses this in the Additional Background Information section for the measure. If a single question screen is used at the health center, it should be recognized by staff as a trigger for conducting alcohol follow-up. This kind of procedure is normally followed with the AUDIT and AUDIT-C screens, as well as other kinds of screens (like depression, etc.). The danger of a single alcohol use question is that it may be buried in a longer instrument for substance abuse and if it does not act as a trigger for further action, the numerator percentage might appear very low for the measure.

The second step is to identify **alcohol counseling** entered into structured data. Again, the workflow for performing alcohol counseling and entering the data in the appropriate location should be formalized among the clinical teams.

According to the HEDIS definition (followed by Partnership), counseling and follow-up can have any of the characteristics below to count toward the measure numerator. Health centers should ensure that the protocols for alcohol counseling meet at least one of the requirements.

- Feedback on alcohol use and harms
- Identification of high-risk situations for drinking and coping strategies
- Increase the motivation to reduce drinking
- Development of a personal plan to reduce drinking
- Documentation of receiving alcohol misuse treatment

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NEW Transformer/Data Element Pair(s) for Alcohol Screens

There are three new Data Elements in Relevant for the three types of alcohol screens described above. These are:

1. AUDIT-C (Data Element audit_c_screens)
2. AUDIT (Data Element audit_screens)
3. Single question alcohol screens (Data Element single_question_alcohol_use_screens)

Configure these Data Elements depending on which screen(s) are used at your health center. Note that the ID numbers for Category ID (catid), Item ID (itemid), and Detail ID (detailid) are unique at each health center and will differ from the example code below. One option to find these ID numbers is with a report from the RCHC Validation Report Set¹¹.

The sample SQL code for the Transformer/Data Element pair below is specifically for the Audit C screen. The Audit screen and the single-question screen may take a similar approach. In the code below, the screen is located in Social History, but it may be in another structured data location at your health center. In any case, health centers are free to design the Transformer/Data Element pair according to their own experiences and best practices with similar structured data items.

Transformer: Build relevant_audit_c_screens

Description: Creates a list of AUDIT-C screens from structured data and displays scores and results
The health center can customize the name of this Transformer to conform to internal norms.

```
DROP TABLE IF EXISTS relevant_audit_c_screens;
CREATE TABLE relevant_audit_c_screens AS
SELECT DISTINCT
  enc.patientid AS patient_id,
  enc.date :: DATE AS performed_on,
  audit_c_score.value AS score,
  CASE WHEN audit_c_interpret.value = 'Positive' THEN TRUE ELSE FALSE END AS positive
FROM enc
  INNER JOIN structsocialhistory AS audit_c_score ON audit_c_score.encounterid = enc.encounterid
  AND audit_c_score.catid = 262111
  AND audit_c_score.itemid = 262128
```

¹¹ eCW health centers can use the validation report “RCHC List All Structured Data Items” available on the RCHC Aggregate. See the presentation New ECDS Measures: Focus on Reports (July 19, 2022) for an example of how to use the report for the alcohol screening measure

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```

AND audit_c_score.detailid = 1004 --Use a unique combination of ID codes to identify the AUDIT-C score in
structured data
AND audit_c_score.value ~ '^d'
LEFT JOIN structsocialhistory AS audit_c_interpret ON audit_c_interpret.encounterid = enc.encounterid
AND audit_c_interpret.catid = 262111
AND audit_c_interpret.itemid = 262128
AND audit_c_interpret.detailid = 1005 --Use a unique combination of ID codes to identify the AUDIT-C
interpretation in structured data
AND NOT audit_c_interpret.value IS NULL
AND NOT audit_c_interpret.value = ''
WHERE enc.deleteflag = 0
AND enc.status = 'CHK';

```

Data Element: AUDIT C Screens

```

SELECT DISTINCT
  patient_id,
  performed_on,
  score,
  positive
FROM relevant_audit_c_screens

```

The column 'positive' must show TRUE if the screen score indicates a positive result. In the example above, the screen interpretation exists in structured data and is therefore used to calculate the 'positive' field. Even though the screen score also exists in structured data (displayed above in the 'score' field), this raw number is not directly evaluated by the Transformer (or subsequently by the report). However, if a score interpretation field does not exist in the EHR (probably rare that it does not), the 'positive' field can be populated using a calculation based on the entered score. Either way, make sure that any positive interpretation is based on national standards (see the table in the Partnership specifications).

NEW Transformer/Data Element Pair for Alcohol Follow-up Counseling

The report identifies alcohol follow-up in three different ways:

1. Alcohol counseling (most common) or other approved follow-up entered into structured data. The health center must identify the location of this counseling and add it to the Data Element named alcohol_counseling_or_other_followups (or associated Transformer). This Data Element should only contain data from structured data (no claims or assessments)
2. A CPT code belonging to the HEDIS Value Set "Alcohol Counseling or Other Follow Up Care" that appears on a claim. No separate Data Element exists for this purpose.

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3. A diagnosis code belonging to the HEDIS Value Set “Alcohol Counseling or Other Follow Up Care” that appears on an Assessment. No separate Data Element exists for this purpose. NOTE that one of the diagnosis codes on this Value Set is a general counseling code ('Z71.89') that is commonly used for many purposes. Therefore, the report will accept this code only if the associated description has the key word ‘alcohol’ in it. In any case, health centers commonly use other codes for alcohol-specific counseling. No separate Data Element exists for this purpose.

Transformer: Build relevant_alcohol_counseling

Description: Creates a list of alcohol counselings from structured data

The health center can customize the name of this Transformer to conform to internal norms.

```

DROP TABLE IF EXISTS relevant_alcohol_counseling;
CREATE TABLE relevant_alcohol_counseling AS
SELECT DISTINCT
  enc.patientid AS patient_id,
  enc.date :: DATE AS performed_on
FROM enc
  INNER JOIN structpreventive ON structpreventive.encounterid = enc.encounterid
WHERE structpreventive.catid = 306460
  AND structpreventive.itemid = 306462
  AND structpreventive.detailid = 1021 --Use a unique combination of ID codes to identify the alcohol counseling
  item(s) in structured data
  AND NOT structpreventive.value IS NULL
  AND NOT structpreventive.value = ''
  AND NOT structpreventive.value ILIKE 'No%' -- Exclude any values indicating the screen was not actually done
  AND enc.deleteflag = 0
  AND enc.status = 'CHK';

```

Data Element: Alcohol Counseling Or Other Followups

```

SELECT
  patient_id,
  performed_on
FROM relevant_alcohol_counseling

```

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NEW Transformer/Data Element Pairs for Exclusions

There are three exclusions for this measure. They are:

1. Patients in hospice any time during the Measurement Period (the Data Element hospice_care_interventions should already exist in Relevant)
2. Patients with alcohol use disorder that starts during the year prior to the Measurement Period. This requires a new Data Element named alcohol_use_disorder_cases. The recommended SQL for the Transformer/Data Element pair is below. Health centers can use any standard approach they have adopted to identify patients by diagnosis codes on the Problem List. Note that Alcohol use Disorder diagnosis codes are identified by a HEDIS Value Set.
3. Patients with a history of dementia any time through the end of the Measurement Period (the Data Element dementia_cases should already exist in Relevant). The recommended SQL is also displayed below, but health centers can use their own standard approach instead. Note that Dementia diagnosis codes are identified by a HEDIS Value Set.

Transformer: Build relevant_alcohol_use_disorder_cases

Description: Displays alcohol use disorder cases, as defined by the HEDIS Value Set

The health center can customize the name of this Transformer to conform to internal norms.

```

DROP TABLE IF EXISTS relevant_alcohol_use_disorder_cases;
CREATE TABLE relevant_alcohol_use_disorder_cases AS
SELECT DISTINCT
    problemlist.patientid AS patient_id,
    itemdetail.value AS code,
    CASE WHEN problemlist.onsetdate ~ '\d\d\/\d\d\/\d\d\d\d'
        THEN problemlist.onsetdate :: DATE
        ELSE LEAST(problemlist.logdate :: DATE, dx.date) END AS started_on,
    CASE WHEN problemlist.resolved = 1 AND problemlist.resolvedon ~ '\d\d\/\d\d\/\d\d\d\d'
        THEN problemlist.resolvedon :: DATE END AS ended_on
FROM problemlist
INNER JOIN itemdetail ON itemdetail.itemID = problemlist.asmtid AND propID = 13
INNER JOIN hedis_value_set_codes
    ON hedis_value_set_codes.code_value = itemdetail.value
    AND hedis_value_set_codes.latest = 'TRUE'
    AND hedis_value_set_codes.value_set_oid =
'2.16.840.1.113883.3.464.1004.1339' -- HEDIS Value Set name: Alcohol Use Disorder
LEFT JOIN (SELECT
    relevant_visits.patient_id,
    itemdetail.value,
    MIN(relevant_visits.visit_date) :: DATE AS date

```

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```

FROM relevant_visits
  INNER JOIN diagnosis ON diagnosis.EncounterId = relevant_visits.id
  INNER JOIN itemdetail ON itemdetail.itemid = diagnosis.itemid
  INNER JOIN hedis_value_set_codes
    ON hedis_value_set_codes.code_value = itemdetail.value
    AND hedis_value_set_codes.latest = 'TRUE'
    AND hedis_value_set_codes.value_set_oid =
'2.16.840.1.113883.3.464.1004.1339' -- HEDIS Value Set name: Alcohol Use Disorder
  WHERE relevant_visits.uds_universe = TRUE
  GROUP BY relevant_visits.patient_id, itemdetail.value
) dx ON dx.patient_id = problemlist.patientid AND dx.value = itemdetail.value
WHERE problemlist.deleteFlag = 0
  AND problemlist.inactiveFlag = 0
  AND problemlist.WUStatus ILIKE 'confirmed'
  AND (problemlist.onsetdate ~ '\d\d\/\d\d\/\d\d\d\d' OR problemlist.logdate ~
'\d\d\/\d\d\/\d\d\d\d');
CREATE INDEX index_relevant_alcohol_use_disorder_cases_on_patient_id ON
relevant_alcohol_use_disorder_cases (patient_id);

```

Data Element: Alcohol Use Disorder Cases

```

SELECT DISTINCT
  patient_id,
  started_on,
  ended_on
FROM relevant_alcohol_use_disorder_cases

```

Transformer: Build relevant_dementia_cases

Description: Displays dementia cases, as defined by the HEDIS Value Set

The health center can customize the name of this Transformer to conform to internal norms.

```

DROP TABLE IF EXISTS relevant_dementia_cases;
CREATE TABLE relevant_dementia_cases AS
SELECT DISTINCT
  problemlist.patientid AS patient_id,
  itemdetail.value AS code,
  CASE WHEN problemlist.onsetdate ~ '\d\d\/\d\d\/\d\d\d\d'
    THEN problemlist.onsetdate :: DATE
  ELSE LEAST(problemlist.logdate :: DATE, dx.date) END AS started_on,
  CASE WHEN problemlist.resolved = 1 AND problemlist.resolvedon ~ '\d\d\/\d\d\/\d\d\d\d'

```

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```

        THEN problemlist.resolvedon :: DATE END AS ended_on
FROM problemlist
    INNER JOIN itemdetail ON itemdetail.itemID = problemlist.asmtid AND propID = 13
    INNER JOIN hedis_value_set_codes
        ON hedis_value_set_codes.code_value = itemdetail.value
        AND hedis_value_set_codes.latest = 'TRUE'
        AND hedis_value_set_codes.value_set_oid =
'2.16.840.1.113883.3.464.1004.1074' -- HEDIS Value Set name: Dementia
    LEFT JOIN (SELECT
        relevant_visits.patient_id,
        itemdetail.value,
        MIN(relevant_visits.visit_date) :: DATE AS date
    FROM relevant_visits
        INNER JOIN diagnosis ON diagnosis. EncounterId = relevant_visits.id
        INNER JOIN itemdetail ON itemdetail.itemid = diagnosis.itemid
        INNER JOIN hedis_value_set_codes
            ON hedis_value_set_codes.code_value = itemdetail.value
            AND hedis_value_set_codes.latest = 'TRUE'
            AND hedis_value_set_codes.value_set_oid =
'2.16.840.1.113883.3.464.1004.1074' -- HEDIS Value Set name: Dementia
        WHERE relevant_visits.uds_universe = TRUE
        GROUP BY relevant_visits.patient_id, itemdetail.value
    ) dx ON dx.patient_id = problemlist.patientid AND dx.value = itemdetail.value
WHERE problemlist.deleteFlag = 0
    AND problemlist.inactiveFlag = 0
    AND problemlist.WUStatus ILIKE 'confirmed'
    AND (problemlist.onsetdate ~ '\d\d\d\d\d\d\d\d\d\d' OR problemlist.logdate ~
'\d\d\d\d\d\d\d\d\d\d');
CREATE INDEX index_relevant_dementia_cases_on_patient_id ON relevant_dementia_cases (patient_id);

```

Data Element: Dementia Cases

```

SELECT DISTINCT
    patient_id,
    started_on
FROM relevant_dementia_cases

```

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Appendix A: List of Value Sets Used in ECDS Quality Measures

Value Sets define the diagnosis codes, medication codes, and procedures codes used by the Quality Measures. The sets are updated by the measure authority every year. The RCHC Data Standards and Integrity Committee recommends that health centers use the Value Sets directly to define these items in their system.

In Relevant, the Value Set codes exist on two tables, depending on the authority source (Value Set Source in the table below). The Relevant tables are “cqm_value_set_codes” and “hedis_value_set_codes.” If the Transformer/Data Element pair has already been established in prior years (usually for ECDS measures overlapping with the UDS measure set), the source is the CQM Relevant table. Other Transformer/Data Element pairs (usually new ones exclusive to the ECDS measure set) rely on the HEDIS Relevant table.

The table below shows the Value Sets for the ECDS Quality Measure set.

Quality Measure Name	Value Set Source	Value Set Description	Value Set OID	Value Set Type
Depression Screening and Follow up	CQM	Depression diagnosis	2.16.840.1.113883.3.600.145	Diagnosis
	CQM	Bipolar Diagnosis	2.16.840.1.113883.3.600.450	Diagnosis
	CQM	Adolescent Depression Medications	2.16.840.1.113883.3.526.3.1567	Medications
	CQM	Adult Depression Medications	2.16.840.1.113883.3.526.3.1566	Medications
Breast Cancer Screening	CQM	History of bilateral mastectomy	2.16.840.1.113883.3.464.1003.198.12.1068	Diagnosis
	CQM	Status Post Left Mastectomy	2.16.840.1.113883.3.464.1003.198.12.1069	Diagnosis
	CQM	Status Post Right Mastectomy	2.16.840.1.113883.3.464.1003.198.12.1070	Diagnosis
	CQM	Unilateral Mastectomy, Unspecified Laterality	2.16.840.1.113883.3.464.1003.198.12.1071	Diagnosis
	CQM	Frailty (Diagnosis, Symptoms and Encounters)	2.16.840.1.113883.3.464.1003.113.12.1074	Diagnosis
			2.16.840.1.113883.3.464.1003.113.12.1075	
			2.16.840.1.113883.3.464.1003.101.12.1088	
	CQM	Palliative care encounter	2.16.840.1.113883.3.600.1.1575	Diagnosis
	CQM	Advanced Illness	2.16.840.1.113883.3.464.1003.110.12.1082	Diagnosis
	CQM	Care Services in Long-Term Residential Facility	2.16.840.1.113883.3.464.1003.101.12.1014	Diagnosis
CQM	Dementia Medications	2.16.840.1.113883.3.464.1003.196.12.1510	Medications	

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Quality Measure Name	Value Set Source	Value Set Description	Value Set OID	Value Set Type
Prenatal Depression Screening and Follow-Up	CQM	Adolescent Depression Medications	2.16.840.1.113883.3.526.3.1567	Medications
	CQM	Adult Depression Medications	2.16.840.1.113883.3.526.3.1566	Medications
Post-partum Depression Screening and Follow-Up	CQM	Adolescent Depression Medications	2.16.840.1.113883.3.526.3.1567	Medications
	CQM	Adult Depression Medications	2.16.840.1.113883.3.526.3.1566	Medications
Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	CQM	Major Depression Including Remission	2.16.840.113883.3.67.1.101.3.2444	Diagnosis
	CQM	Dysthymia	2.16.840.1.113883.3.67.1.101.1.254	Diagnosis
	CQM	Bipolar Disorder	2.16.840.1.113883.3.67.1.101.1.128	Diagnosis
	CQM	Personality Disorder	2.16.840.1.113883.3.67.1.101.1.246	Diagnosis
	CQM	Pervasive Developmental Disorder	2.16.840.1.113883.3.464.1003.105.12.1152	Diagnosis
	CQM	Schizophrenia or Psychotic Disorder	2.16.840.1.113883.3.464.1003.105.12.1104	Diagnosis
Depression Remission or Response for Adolescents and Adults	CQM	Major Depression Including Remission	2.16.840.113883.3.67.1.101.3.2444	Diagnosis
	CQM	Dysthymia	2.16.840.1.113883.3.67.1.101.1.254	Diagnosis
	CQM	Bipolar Disorder	2.16.840.1.113883.3.67.1.101.1.128	Diagnosis
	CQM	Personality Disorder	2.16.840.1.113883.3.67.1.101.1.246	Diagnosis
	CQM	Pervasive Developmental Disorder	2.16.840.1.113883.3.464.1003.105.12.1152	Diagnosis
	CQM	Schizophrenia or Psychotic Disorder	2.16.840.1.113883.3.464.1003.105.12.1104	Diagnosis
Follow-Up Care for Children Prescribed ADHD Medication	CQM	ADHD Medications	2.16.840.1.113883.3.464.1003.196.12.1171	Medications
	HEDIS	Narcolepsy	2.16.840.1.113883.3.464.1004.1182	Diagnosis
Unhealthy Alcohol Use Screening and Follow-Up	HEDIS	Alcohol Counseling or Other Follow Up Care	2.16.840.1.113883.3.464.1004.1437	Diagnosis and procedure
	HEDIS	Alcohol Use Disorder	2.16.840.1.113883.3.464.1004.1339	Diagnosis
	HEDIS	Dementia	2.16.840.1.113883.3.464.1004.1074	Diagnosis

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Appendix B: New ECDS Quality Measures, Transformers and Data Elements

Below is a list of the completely new ECDS Quality Measures, Transformers and Data Elements that need to be added, configured, and validated in health center instances of Relevant.

Measure Name	Report Name	Transformer Name (Health Center Can Change or Customize)	Data Element Name
Prenatal Depression Screening and Follow-Up	Prenatal Depression Screening and Follow-Up (Aligns With 2022 HEDIS Measure PND)	Build relevant_edinburgh_screen	Edinburgh Depression Screens
Post-partum Depression Screening and Follow-Up	Postpartum Depression Screening and Follow-Up (Aligns With 2022 HEDIS Measure PDS)	Build relevant_edinburgh_screen	Edinburgh Depression Screens
Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (Aligns With 2022 HEDIS Measure DMS)	No new Transformers are required for this measure	No new Data Elements are required for this measure
Depression Remission or Response for Adolescents and Adults	Depression Remission or Response for Adolescents and Adults: Follow-Up PHQ-9 (Aligns With 2022 HEDIS Measure DRR)	No new Transformers are required for this measure	No new Data Elements are required for this measure
	Depression Remission or Response for Adolescents and Adults: Depression Response (Aligns With 2022 HEDIS Measure DRR)	No new Transformers are required for this measure	No new Data Elements are required for this measure
	Depression Remission or Response for Adolescents and Adults: Depression Remission (Aligns With 2022 HEDIS Measure DRR)	No new Transformers are required for this measure	No new Data Elements are required for this measure
Follow-Up Care for Children Prescribed ADHD Medication	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase (Aligns With 2022 HEDIS Measure ADD)	Build relevant_adhd_prescriptions	ADHD Prescriptions

Configuring the RCHC Relevant QIP ECDS Quality Measures

Measure Name	Report Name	Transformer Name (Health Center Can Change or Customize)	Data Element Name
	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase (Aligns With 2022 HEDIS Measure ADD)	Build relevant_adhd_prescriptions	ADHD Prescriptions
Unhealthy Alcohol Use Screening and Follow-Up	Unhealthy Alcohol Use Screening and Follow-Up (Aligns With 2022 HEDIS Measure ASF)	Build relevant_audit_c_screens	AUDIT C Screens
		Build relevant_audit_screens	AUDIT Screens
		Build relevant_single_question_alcohol_use_screens	Single Question Alcohol Use Screens
		Build relevant_alcohol_counseling	Alcohol Counseling Or Other Followups
		Build relevant_alcohol_use_disorder_cases	Alcohol Use Disorder Cases
		Build relevant_dementia_cases	Dementia Cases