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# Clinical and Quality Measures: FAQ

## Don’t see your question here? Email Carly Levitz at carly.e.levitz@kp.org

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**General reporting**

1. We have multiple clinics/sites within our organization. For which do we need to report PHASE data on a quarterly basis?

Report data for all clinics/sites that are participating in PHASE. “Participation” could include clinics/sites that are implementing QI work, implementing team-based care models, receiving training from CCI or coaching from TMIT, using the PHASE medication protocol (“PHASE on a Page”), etc.

1. Could you clarify if there’s a difference between “during the past measurement year” and “during the measurement year”?

They are the same thing. For example, for Q2 of 2017, they are both referring to the period of 7/1/2016 to 6/30/2017.

1. Do we need to report all measures, or can we choose a subset of measures?

The grant requirement is to report all measures on a quarterly basis. We recognize that there may be initial challenges or delays with reporting on some measures.

1. We would like to focus our efforts on a subset of the full population. Can we report on that subpopulation for the quarterly reporting?

The grant requirement is to report the measures as they are defined in the reporting template, using the denominators that are explicitly defined. To be consistent across grantees, we are asking grantees to report on the population similarly. For your own improvement efforts, we encourage you to segment the population to align with your areas of focus.

1. Will we receive anything after we report the quarterly data?

Each grantee will receive dashboards of their reported data within one month after data submission. The first dashboards may take longer to produce. The cascading dashboards are at three levels: the initiative, the grantee, and the sub-grantee. The sub-grantees are participating hospital sites of a hospital grantee, participating health center organizations of a consortium grantee, and participating clinic sites of a health center grantee.

1. As a hospital, can we report the PRIME measures for the relevant PHASE measures?

Yes.

1. \*NEW\* On the dashboards, what is the PHASE grantee average?

It is the average for a given measure for all grantees, regardless of type (health center, hospital, consortium). The average sums the numerator and denominator for the smallest unit available (e.g., health center of a consortium, hospital site) so as to take into account the wide variation in population sizes by grantee.

**Hypertension definition**

1. Is Hypertension just defined using the code of I10?

It is only ICD10 – essential hypertension. The 2016 HEDIS Specs, which is what the PHASE measures are based on, has the diagnosis as follows: “Members are identified as hypertensive if there is at least one outpatient visit (Outpatient Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) during the first six months of the measurement year.” The value set for essential hypertension is only ICD I10.

1. Who is included in the HTN patient definition of “patients with an outpatient diagnosis of hypertension during the first 6 months of the measurement year or prior?

It includes patients with a diagnosis of HTN who received that diagnosis *at any point prior to 6 months to the end of the measurement year.* For example, for Q4 2018 (with the measurement year of 1/1/2018 to 12/31/2018), it would include patients who had a diagnosis of hypertension *at any point* prior to 6/30/2018.

**ASCVD definition**

1. For the ASCVD patients, should we be looking at all active patients or patients with a diagnosis from the list in the last year?  This question stems from the fact that there is a time frame for the DM patient measure (2 outpatient visits in the measurement year) and for the HTN patient measure (HTN diagnosis in the first 6 months of measurement year), but *no* specification of a visit rule for ASCVD.  Can you please clarify?

The ASCVD population measure is for all active patients, in whatever way the clinics define “active.” Because the DM and HTN measures are linked to HEDIS, there are specific definitions for what “active” means, which isn’t the case for ASCVD. The ASCVD population measure does not roll up into any of the other denominators; in terms of being “accountable” for patients who may no longer be at your clinic, there are no consequences to the lack of a visit rule. However, if the added nuance of a visit rule is more actionable for you, feel free to add one that works within your operationalized definition of an active patient.

**Unduplicated patients definition**

1. How do you define unduplicated total patients?

It is the number of unique patients with ASCVD, diabetes, and/or HTN. It is not the sum of the three diagnostic categories because some individuals will have diagnoses of more than one of these conditions.

**HEDIS percentiles**

1. \*NEW\* What do the HEDIS 75th and 90th percentiles represent?

HEDIS percentiles are calculated by NCQA each year based on the broad categories of health plans (e.g., commercial, Medicaid, Medicare, etc.). Though we realize you submit data for all patients at participating sites, regardless of their insurance coverage, PHASE benchmarks with NCQA’s Medicaid numbers because that population most closely resembles patients served by PHASE grantees.

The 75th percentile means that 75% of organizations submitting data are below that value. The 90th percentile means that 90% of organizations submitting data are below that value.

**Blood pressure**

1. Does a patient have to have systolic blood pressure less than the threshold AND diastolic less than the threshold to be considered “in control”? Or is it an “or”?

For patients aged 18-59 and patients aged 60-85 with a diagnosis of diabetes: a) systolic needs to be under 140 ***and*** b) diastolic needs to be under 90.

For patients aged 60-85 without a diagnosis of diabetes: a) systolic needs to be under 150 ***and*** b) diastolic needs to be under 90.

1. How does HEDIS specify how to record multiple blood pressure measurements in the same visit?

If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading.

**Diabetes A1c**

1. The diabetes control measure is the inverse of the HEDIS measure. Can we report the HEDIS measure, which is for poor control (>9% or missing), instead?

Yes. If it is more actionable for you to report out of control A1c or it aligns better with your other reporting requirements, you may report out of control A1c. However, be sure to let Carly Levitz know that you are reporting the measure as out of control.

**Follow-up definitions**

1. What is the PHASE definition of follow-up for the tobacco, BMI, and depression screening & follow-up measures?

There is no PHASE-specific definition for follow-up for these measures. It is more important that the definition is operational within your system. Please review the PHASE Clinical and Quality Measures Reporting Template for examples of what you could use as follow-up. As a reminder, regardless of how you define follow-up, you are required to report on the combined measure of both screening and follow-up.

**BMI**

1. If a patient is only seen in the first 6 months of a reporting year, had their BMI measured during that visit, and has not had another visit in the final 6 months of the reporting year, and they otherwise meet the criteria for inclusion in the numerator, should they be included in the numerator?

The UDS reporting instructions for 2016, which is what the PHASE measures are based on, has the numerator defined as follows (underlining was done by me): “Patients with a documented BMI (not just height and weight) during their most recent visit or during the previous six months of the most recent visit, and when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous six months of the current visit.” Given what is in the underlined section, I believe that the patient you described would be numerator compliant.

1. [In previous reporting templates prior to 2019:] What is the source of 23 to 30 as normal range for those 65 years and over? Most organizations like CDC, WHO are still using 18.5 to 25 as recommendations for all adults. Furthermore, the threshold for UDS (lower) is 18.5. Is there flexibility with leaving the lower threshold as 18.5 to be consistent?

There is not a differentiation by age of normal parameters of BMI. The PHASE reporting template has been updated to reflect this. The research on BMI ranges for the elderly is mixed. Please see the [guidance section of the eCQI](https://ecqi.healthit.gov/ecqm/measures/cms69v7) specification to see the sources.

1. Does the source consider exceptions for Asian populations? Current research suggests that for Asian populations have different associations between BMI, body fat % and health risks than do other populations ([WHO](https://urldefense.proofpoint.com/v2/url?u=https-3A__www.who.int_nutrition_publications_bmi-5Fasia-5Fstrategies.pdf&d=DwMFAg&c=ZMR5nv7DeMA_5yIzV7zEdkSfOjTGya0xwGqp1JcaTq0&r=0zJrzmVOKYHQj93ii3944_G3TCyoX1YUeUdSb_7PZq0&m=xmiuN01uyxbbUPywXE99e9UWmu_b1HZ-7L4h-6wrTTE&s=glxoG4Op579cq6V9j5D9OsRIgSnj0aR0kz691G-G7qc&e=)).

The source does not consider exceptions for Asian populations. clinics should operationalize these measures in such a way to benefit their patient populations. While the specifications are what they are, we’d like for folks to report them as close to the specs as possible – but we recognize that individualized, whole-person patient care means that sometimes these recommendations are not appropriate for each patient.

**Tobacco**

1. What is the difference between the previous tobacco measure and the new tobacco measure?

**Regarding CMS138v6:** **Tobacco Use: Screening and Cessation Intervention:** Due to updates in the guidance and specification of CMS138 from 2017 to 2018 by the Centers for Medicare and Medicaid Services (CMS), health centers may see a difference in their “Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention” clinical quality measure percentage in their 2018 Uniform Data System (UDS) report. This difference stems from the change in the measure logic summarized below:

[CMS138v5](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttps-253A-252F-252Fecqi.healthit.gov-252Fecqm-252Fmeasures-252Fcms138v5-26data-3D02-257C01-257C-257C2a175feb74bb480c366208d63510d42d-257C4ab45fb85da44f308ddc041fc7015aa3-257C0-257C0-257C636754743728523800-26sdata-3DPucREPOSoUea-252BKNtll6L-252B-252B2ZtpRW5UGqIyv1NqrgHuU-253D-26reserved-3D0&d=DwMFAg&c=ZMR5nv7DeMA_5yIzV7zEdkSfOjTGya0xwGqp1JcaTq0&r=0zJrzmVOKYHQj93ii3944_G3TCyoX1YUeUdSb_7PZq0&m=bz4ykz5rIsAw586z3PfIs9TgTHkd6FqIEaf_1bz1wIE&s=T32SLRcXf-ulmFr5y1cmAZUSd0IY5RR0U9JnfDmV14Y&e=) (2017): Evidence of tobacco cessation intervention must occur within 24 months of the end of period (e.g., the end of 2017).

[CMS138v6](https://urldefense.proofpoint.com/v2/url?u=https-3A__na01.safelinks.protection.outlook.com_-3Furl-3Dhttps-253A-252F-252Fecqi.healthit.gov-252Fecqm-252Fmeasures-252Fcms138v6-26data-3D02-257C01-257C-257C2a175feb74bb480c366208d63510d42d-257C4ab45fb85da44f308ddc041fc7015aa3-257C0-257C0-257C636754743728523800-26sdata-3DPPKFiMQ2kTJM-252FGMael3yBPDxPc8k3oQt7jjWFz9H75w-253D-26reserved-3D0&d=DwMFAg&c=ZMR5nv7DeMA_5yIzV7zEdkSfOjTGya0xwGqp1JcaTq0&r=0zJrzmVOKYHQj93ii3944_G3TCyoX1YUeUdSb_7PZq0&m=bz4ykz5rIsAw586z3PfIs9TgTHkd6FqIEaf_1bz1wIE&s=PJYNMrY_rRYZudUj8VkrzdeSFKmnumVxzo8uUsMgxAg&e=) (2018): Evidence of tobacco cessation intervention must start *concurrent with* or *after* the most recent tobacco use screening. Health centers must also use the most recent screening which has a documented status of tobacco user or tobacco non-user to satisfy the measure.

The Health Resources and Services Administration is aware of the measurement change, and health centers should continue to follow the specifications from CMS on this measure. Please feel free to share this note with your networks and/or other UDS stakeholders.

<https://ecqi.healthit.gov/ecqm/measures/cms138v6>

1. How do you anticipate the change in measure specification will impact our rates?

This change may cause a reduction of up to 6% in the performance percentage for some health centers.

**Prescription of medications**

1. What does it mean to have a medication order current during the measurement year?

Individual grantees can decide how best to operationalize this definition within their system. It could be that the medication order was current at any point during the measurement year, current during the entire year, or somewhere in between.

1. For the medication measures, are the patients who have drug-allergy or drug-drug interaction contraindication included or excluded?

Short answer: they can be excluded.

Long answer: The medication measures’ denominators, in the most ideal scenarios, would be only patients for whom the drug is indicated. For this evaluation, we realize that not all grantees would be able to track this, so we didn’t use that as the denominator. We instead use the population that is most likely to be indicated for the medications: diabetics aged 55-75 and those with hypertension aged 18-85.

1. In the provided list of oral medications for hypertension, Hydrochlorothiazide was not listed as an isolated drug, it is only listed in combination with other drugs. In the definition, there is a note that says, "if there are additional medications that you think are appropriate, please use your expert judgment." Can Hydrochlorothiazide be considered a medication for this measure as an isolated drug?

Yes, Hydrochlorothiazide should be included by itself as an oral anti-hypertensive medication. This was an oversight.

**Published resources**

1. Do you know of any research that has been done comparing the clinical health outcomes of patients who are part of PHASE versus those who are not?

There are three articles that may be of interest:

* Dudl JR, Wang MC, Wong M, Bellows J. Preventing myocardial infarction and stroke with a simplified bundle of cardioprotective medications. *Am J Manag Care.* 2009; 15(10): e88-e94.
* Gold R, Nelson C, Cowburn S, et al. Feasibility and impact of implementing a private care system’s diabetes quality improvement intervention in the safety net: a cluster-randomized trial. *Implementation Science* 2015; 10(83): DOI 10.1186/s13012-015-0259-4.
* Wong W, Jaffe M, Wong M, Dudl JR. Community implementation and translation of Kaiser Permanente’s cardiovascular disease risk-reduction strategy. *The Permanente Journal* 2011; 15(1): 36-41.

\*NEW\* **Alignment with other reporting requirements**

|  |  |  |
| --- | --- | --- |
| **Measure Name** | **Alignment** | **Link** |
| Tobacco use: screening & cessation intervention | CMS 138 | https://ecqi.healthit.gov/ecqm/measures/cms138v6 |
| Tobacco use: screening & cessation intervention | NQF 0028 | https://www.ncdr.com/WebNCDR/docs/default-source/pinnacle-public-documents/2018\_measure\_226\_registry.pdf?sfvrsn=6 |
| BMI screening & follow-up plan | CMS 69 | https://ecqi.healthit.gov/ecqm/measures/cms69v7 |
| BMI screening & follow-up plan | NQF 0421 | <https://www.apta.org/MIPS/2018/Measure128/> |
| Screening for depression & follow-up plan | CMS 2 | https://ecqi.healthit.gov/ecqm/measures/cms2v8 |
| Screening for depression & follow-up plan | NQF 0418 | https://www.acr.org/-/media/ACR/NOINDEX/Measures/2018\_Measure\_134\_Registry.pdf |
| A1c poor control (>9%) | CMS 122 | https://ecqi.healthit.gov/ecqm/measures/cms122v7 |
| A1c poor control (>9%) | NQF 0059 | https://www.ncdr.com/WebNCDR/docs/default-source/pinnacle-public-documents/2018\_measure\_001\_registry.pdf?sfvrsn=8 |
| Hypertension blood pressure control | CMS 165 | https://ecqi.healthit.gov/ecqm/measures/cms165v7 |
| Hypertension blood pressure control | NQF 0018 | https://www.acr.org/-/media/ACR/NOINDEX/Measures/2018\_Measure\_236\_Registry.pdf |
| Diabetes blood pressure control | NQF 0061 | <http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1235&print=0&entityTypeID=1> |

**PHASE reporting checklist: courtesy of CHCN (https://chcnetwork.org)**

*Please use following rules to check numbers in PHASE report before submitting.*

*By doing this, you validate the data quality, and the performance rate will be more accurate.*

**Overall**

1. Each measure’s numerator should be smaller than its denominator

**Patient population**

1. Total unduplicated patients (row 19) should be greater than each of diabetes/ ASCVD/ hypertension patient populations separately (rows 16, 17, 18)
2. The sum of diabetes/ASCVD/hypertension patients (row 16, 17, 18) should be greater than unduplicated patients (row 19)

**Prescription**

1. Diabetes prescription denominator (rows 23, 25, 27; age 55-75) should be smaller than diabetes population (row 16; age 18-75)
2. Three diabetes prescription denominators should be the same (rows 23, 25, 27)
3. Diabetes statin and ACE/ARB numerator (row 26) should be smaller than diabetes statin numerator (row 22) and diabetes ACE/ARB numerator (row 24) separately
4. Hypertension prescription denominator (row 29) should be the same as hypertension population (row 18)

**Screening and follow-up**

1. Screening and follow-up denominators (row 34, 36, 38, 40, 42) should be greater than unduplicated patients (row 19)
2. Generally, depression denominator (row 42) should be greater than the denominators of BMI and tobacco (rows 38, 40)

**Clinical quality**

1. Diabetes denominators (rows 46, 48) should be equal to diabetes population (row 16)
2. Hypertension denominator (row 50) should be equal to hypertension population (row 18)

**Compare with last quarter data**

If the difference is more than 10%, think of…

1. Have you done anything differently from data side?
2. Has your clinic done anything differently in terms of clinical practice?
3. Have data definitions changed?
4. Any other things that might cause this?

Thanks to the CHCN team for providing their data reporting check-list!