The RIDOH CCE Program and its Commitment to the QRS

November 17, 2022

RHODE ISLAND

Introduction

- Welcome & Introductions
- Brief History of the RI CCE Chronic Disease Program
- The Transition to CMS eCQMs
- The Transition to the QRS
- The QRS Use Case
- Going Forward

What is the RIDOH CCE Chronic Disease Program

CCE = Care + Community + Equity

1. The RIDOH Diabetes (DM), Heart Disease and Stroke Program (DHDS) at the Rhode Island Department of Health
2. Aimed at improving care and health outcomes for people with or at risk for cardiovascular disease, and diabetes
3. Scope of work includes:
    - Identify patients with uncontrolled hypertension (HTN) (diagnosed and undiagnosed), Diabetes / Pre-Diabetes and elevated cholesterol and refer them to evidence-based lifestyle programs Identify patients with elevated cholesterol and refer them to evidence-based lifestyle programs
    - Support the adoption and use of clinical quality measures at the clinic and/or provider-level to screen and manage patients.
    - Track improvements in screening and disease management by implementing quality improvement (QI) activities)

Care + Community + Equity Sites

CCE QRS Sites

1. Thundermist Health Center
2. TriCounty Health Center
3. CCAP Health Center
4. Wood River Health Center

CCE Non QRS Sites (Currently)

1. RI Free Clinic
2. Clinica Esperanza

CCE: 2022 Core and Incentive Deliverables

Core Deliverables

1. Practice Facilitation (quarterly site visits)
2. Data submissions (quarterly)
3. Risk stratification of patient population
4. Best practice sharing
5. Referrals to evidence-based programs within the CHN

Incentive Deliverables

1. Meet Targets for DM, HTN (diagnosed and undiagnosed), Statin Therapy, and Self-Measured Blood Pressure (SMBP)
2. Patient/provider/practice success stories
3. Million Hearts recognition opportunities - Plan to identify clinicians and health care systems that have made successful innovations in hypertension control during the time of COVID-19
4. AHA Recognition Opportunities – Target: BP, CCCC, Know Diabetes by Heart

CCE: Quality Reporting System - Optional Addendum

Year 3

1. QRS Onboarding – Data validation and mapping
    - Diabetes in Poor Control - (CMS122v8)
    - HTN in Control - (CMS165v8)
    - Statin Therapy - (CMS347v3)

Year 4

1. Complete validation

2. Use QRS for Quality Improvement
    - QRS “Use Case”

The Transition to CMS eCQMs

1. CDC (the funder of CCE program) initially did not specify a requirement to use eCQMs. In earlier iterations of the program clinics (predominantly health centers) had been encouraged to configure their EHRs to appropriately manage their screening programs and report progress

2. With the agreement of CDC, it was decided to use the following measures to manage the program as the FQHCs already were reporting them to HRSA under their UDS reporting requirements:
   - Diabetes in Poor Control (CMS122)
   - HTN in Control (CMS165)
   - Statin Therapy (CMS347)

   To align with the CDC program requirement these measures were slightly modified to include additional race / ethnicity stratification and more flexible reporting periods. In addition, one more measure was specified by the CCE team that were not eCQMs (no existing measure met the program requirements):
      - Elevated Blood Pressure without Hypertension Diagnosis

In 2020 IMAT built the 3 eCQM measures in the QRS. These were updated to the 2022 specifications this year and will be updated annually going forward.

CCE Reporting

1. Clinics reporting to CCE aew required to report **by site** on a quarterly meeting. A portal was developed (by CTC) to allow this data to be uploaded by the clinics

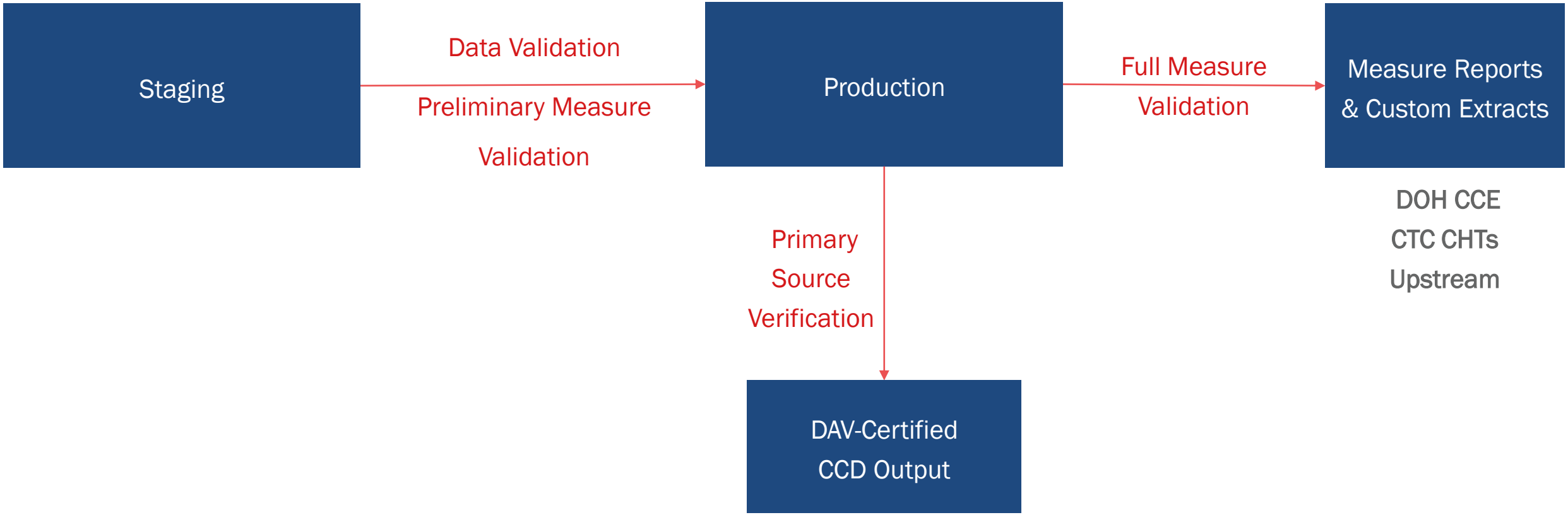
Account Name	Period Ending	Focus Area	Measure	Number	Numerator	Denominator	Rate	Measure Annotation	Shiny Approval DOH1	DOH Metric: DOH Metric Number	DOH Metric: Created Date
CCAP - Coventry	Q3 2022	Cardiovascular Disease Prevention	Adult Patient Panel	1813					1	DM-003580	10/18/2022
CCAP - Coventry	Q2 2022	Cardiovascular Disease Prevention	Adult Patient Panel	1730				Re-entering 2nd Q data	1	DM-003752	10/31/2022
CCAP - Coventry	Q1 2022	Cardiovascular Disease Prevention	Adult Patient Panel	1623				Re-entering 1st Q data	1	DM-003740	10/31/2022
CCAP - Coventry	Q3 2022	Cardiovascular Disease Prevention	HTN: BP in Control (<140/90mmHg)		375	567	66.1		1	DM-003581	10/18/2022
CCAP - Coventry	Q2 2022	Cardiovascular Disease Prevention	HTN: BP in Control (<140/90mmHg)		335	524	63.9		1	DM-003753	10/31/2022
CCAP - Coventry	Q1 2022	Cardiovascular Disease Prevention	HTN: BP in Control (<140/90mmHg)		316	494	64		1	DM-003741	10/31/2022
CCAP - Coventry	Q3 2022	Cardiovascular Disease Prevention	Statin Therapy for Prevention and Treatment of CVD		206	284	72.5		1	DM-003583	10/18/2022
CCAP - Coventry	Q2 2022	Cardiovascular Disease Prevention	Statin Therapy for Prevention and Treatment of CVD		193	261	73.9		1	DM-003755	10/31/2022
CCAP - Coventry	Q1 2022	Cardiovascular Disease Prevention	Statin Therapy for Prevention and Treatment of CVD		195	251	77.7		1	DM-003743	10/31/2022
CCAP - Coventry	Q3 2022	Cardiovascular Disease Prevention	Undiagnosed Hypertension		50	844	5.9		1	DM-003646	10/25/2022

The Transition to the QRS

1. So, in 2019 the partner FQHCs were offered an addendum to their contracts in which incentives would be earned if they worked with the CCE group to transition their CCE reporting to the QRS, the rationale being:
   - The site level CCE reporting was somewhat onerous and the QRS offered an opportunity to reduce the burden.
   - The QRS offered an enhanced data analytic capability to stratify the data and identify care gaps
   - The FQHCs were already partway through the QRS onboarding process.

2. FQHCs agreed and have since been working with CCE on data validation and the resolution of the resulting technical issues.

Full Measure Validation



What is the Data Validation Process?

- Working with CCAP IMAT / EOHHS piloted the measure validation process:
  - The agency and IMAT created a Data Validation Plan for each measure that includes the validation methodology and success criteria.
  - IMAT performed an initial validation to ensure that all the data elements required by the measure are populating and the data is within the expected range.
  - Working with the provider organization, a small number of patients were selected, and the data correlated between the two systems. Where anomalies are found, the reason(s) are identified and corrected. Note that the correction may occur at the EHR or IMAT “end”. This process was repeated until systemic issues were resolved.
  - The measure is run against a defined population and date range in both the EHR and IMAT and correlated. Again, anomalies are identified and corrected until resolved.
  - The final stage of validation was to run the measure from both QRS and EHR on a large population (Full year 2021 data set).

- Using 100% of their adult population for all of 2020, CCAP was able to correlate their data within 2-3%:
  - CMS122v8 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
  - CMS165v8 Controlling High Blood Pressure

QRS Use Case Demonstration Project

Work Completed so far by the four partner FQHCs:

- ✓ Work with IMAT to complete the data mapping process for each of the following measures:
  - Diabetes in Poor Control
  - HTN in Control
  - Statin Therapy
- ✓ Continue to implement the data validation plan submitted during the previous contract year. Throughout the data validation process, resolve issues or errors for each measure independently with IMAT and / or with support from the EHR consultant.
- ✓ To demonstrate completion of data validation, submit results or final reports for each measure to RIDOH and the EHR consultant for approval.

- Current Period of Performance Scope:
  - June 30th, 2022 – September 29th, 2023

Care + Community + Equity: Quality Reporting System

Goals:

- Regularly work with an EHR consultant to review the QRS data reports per measure and develop ways to use QRS data for continuous quality improvement.
- Analyze existing data (i.e., UDS 2021 data), and identify and define potential population health care inequities or care gaps.
- Use the QRS data to "drill down" into the data, to better understand elements of the practice's problem statement.
    - Note: QRS data should be analyzed at an actionable, patient-level. Link data sources to pinpoint actionable, patient-level data that could result in improvement with implemented interventions.
- Create and outline a quality improvement plan (inclusive of patient-level intervention(s)) to implement.
- Identify control mechanism(s) (i.e., revised policies, procedures, staff trainings) to establish for long-term actions that maintain improvement in measures observed.

National Association of the Chronic Disease Directors

In August 2022, the National Association of Chronic Disease Directors' Board of Directors and Impact Awards Committee selected the Diabetes, Heart Disease and Stroke Program within the Rhode Island Department of Health for the 2022 Chronic Disease Innovator Award for Chronic Disease Units

The Chronic Disease Innovator Award is given to a state, tribal, or territorial Chronic Disease Unit that demonstrates an innovative approach to reducing the burden of chronic disease prevention and control. Rhode Island demonstrated their health system transformation through health information technology, including the implementation of the Quality Reporting System.

Thank You for your time and thanks to:

- RI DOH CCE Program
- RI EOHHS
- CCE QRS Sites
  - Thundermist Health Center
  - TriCounty Health Center
  - CCAP Health Center
  - Wood River Health Center
- CCE Non QRS Sites (Currently)
  - RI Free Clinic
  - Clinica Esperanza
- IMAT Technologies
- RI EOHHS