CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Quality Measures Methodological Notes

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The Institute of Medicine (2001) defines quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Using CO APCD data, CIVHC has produced two nationally-endorsed[1] quality measures used by national and state-sponsored programs.

Preventive Care: This report includes one preventive measure. Preventive care is an important part of health care quality by helping populations remain healthy. The measure of preventive care included in this report is:

Breast Cancer Screening: This measure represents the percentage of women 50 to 74 years old who had one or more mammograms to screen for breast cancer during the measurement year and two years prior to the measurement year.

Appropriate Medical Treatment: This report also includes one measure that indicates if a condition is being managed according to current professional knowledge. Managing chronic conditions appropriately is an important part of health care quality because it prevents further complications in populations who already have a disease. The measure included in this report is Diabetes A1c testing.

Diabetes A1c testing: This measure represents the percentage of patients 18 to 75 years old, with diabetes type I or II who received an HbA1c test during the measurement year.

Demographic Characteristics

Demographic characteristics reflect the information available in the most recent record of a person in a calendar year. For example, if the most recent record is from the month of March 2017, then the person's location of residence, gender, and other demographic information will be as of March 2017. The only exception is for age, which is calculated as of December 31st of the reporting year. Quality measures have specific age range and, in some cases, age subgroup requirements.

Only residents of Colorado are reflected in the data. State resident status is determined based on the most recent insurance eligibility record available in a given year, which indicates whether the person resides in a ZIP code within Colorado. All calculations are based on where Colorado residents live, not where they received care.

Geographic Groupings

Geographic breakdowns available in the report are rural and urban county groups and Statewide. The rural and urban county classification is based on the U.S. Office of Management and Budget county-level

[1] The quality measures used in this report which are endorsed by the National Qualify Forum(NQF) are: Breast Cancer Screening NQF 2372 and Diabetes HbA1c testing NQF 0057. The logic used to produce these HEDIS® measure results has not been certified by NCQA. Such results are for reference only and are not an indication of measure validity.

designation: counties that are part of a Metropolitan Statistical Area are considered "urban"; all other counties are considered "rural".[2] The following is a list of rural and urban Colorado counties:

- Urban counties (17): Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Jefferson, Larimer, Mesa, Park, Pueblo, Teller, and Weld;
- Rural counties (47): Alamosa, Archuleta, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, La Plata, Lake, Las Animas, Lincoln, Logan, Mineral, Moffat, Montezuma, Montrose, Morgan, Otero, Ouray, Phillips, Pitkin, Prowers, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Washington, Yuma.

Payer Types

The payer types available in this report are: Commercial, Medicaid, Medicare Advantage, Medicare Fee-For-Service (Medicare FFS), and a combination of all four types labeled as "All Payers."

For report measures other than the quality measures, payer type is created by assigning each person to an *annualized* payer type based on their primary medical insurance information during a reporting year, regardless of whether the person had insurance for just a single month, the full year, or any number of months in-between. The annualized assignment is based on the payer type with the highest number of months with (a) commercial, (b) Medicaid, or (c) Medicare Advantage or Medicare FFS insurance, summed together. In the event of a tie in the number of months with insurance for two or more payer types, a secondary logic step looks at the count of claims within each of those payer types and an assignment is made to the type with the highest claim count. For example, a person with commercial insurance for six months with ten commercial claims and Medicare Advantage insurance for the other six months and with three Medicare Advantage claims will receive the commercial payer type at the annual level. A person with a greater number of Medicare months than Medicaid or commercial, and with the same number of Medicare FFS and Medicare Advantage months and claims, will be assigned to Medicare FFS payer time at the annual level.

Pharmacy and dental insurance eligibility information, or secondary insurance information, is not considered when assigning a payer type. Once a person is assigned a payer type, all medical and pharmacy claim records for that person are associated with that assignment, regardless of the insurance type information on the claim record.

For quality measures, payer type is defined based on primary insurance information at the person-eligibility-month level with additional measure- and payer-type specific criteria for continuous enrollment during the time frame specific to each measure.

Data Suppression

Following privacy protection standards used by the Centers for Medicare & Medicaid Services (CMS), data are suppressed for values based on fewer than 11 units, for example, cost PPPY values based on fewer than 11 insured-years or emergency room rates based on fewer than 11 visits. Throughout the

[2] Colorado Rural Health Center (2016). *Colorado: County Designations, 2016.* Retrieved from http://coruralhealth.wpengine.netdna-cdn.com/wp-content/uploads/2016/03/2016.CountyDesignations.pdf on July 13, 2017.

dashboard and the underlying detailed data in spreadsheet format, data points impacted by low volume are displayed as asterisks on the dashboard and as blank cells in the detailed data spreadsheet.

Data Limitations

Data presented in this report are the result of a process that strives to ensure high quality, reliability, and accuracy information. Potential areas of concern are investigated and addressed accordingly, on a regular basis, and while every effort is made to address all known areas of concern for this report, some may remain.

Data for small population breakdowns or for rare events should be interpreted with caution, since they are prone to significant fluctuations. Colorado counties that typically have had small populations (fewer than 5,000 people overall) at one point during the reporting time frame include: Baca, Cheyenne, Costilla, Custer, Dolores, Gilpin, Hinsdale, Jackson, Kiowa, Lincoln, Mineral, Ouray, Phillips, San Juan, Sedgwick, Saguache, and Washington.

Data Vintage

Information regarding the payers represented in this public report:

- Current CO APCD Data Submitters List
- Percent of insured individuals in the CO APCD by county

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