# MAY 2023 ECDE SUBGROUP MEETING

Wednesday, May 10, 2022 (11:00 am – 12:00 pm)
Via Microsoft Teams

FACILITATOR: ADRIAN BISHOP AND KASH

| AGENDA ITEM | KEY DISCUSSION POINTS | NEXT STEPS |
|---|---|---|
| 1. INTRODUCTION | • Charlie Estabrook, Adrian Bishop and Kash welcomed the ECDE Subgroup and reviewed the agenda. | |
| 2. REVIEW ECDE SUBGROUP EXPECTATIONS | • Adrian summarized the Subgroup expectations discussed at the prior meeting. | |
| 3. REVIEW CURRENT MEASURE VALIDATION ACTIVITIES | • Adrian described current data validation activities, including primary source validation (PSV) and measure validation as well as how they relate to the previously discussed topics of data fidelity and data completeness.<br>• Mark Marinello recommended revising the definition of completeness to "minimum necessary completeness." He said that Coastal is sharing more data than is necessary to calculate measure performance because of the churn associated with the Medicaid population.<br>  ○ John Hinesly said payers will give providers at least two years of historical data on a patient if the patient agrees with HIPAA data sharing standards.<br>  ○ Mark clarified that he was concerned about Coastal continuing to send data on patients who may no longer be Medicaid patients.<br>  ○ Liv King said IMAT receives updated member lists from all plans on at least a monthly basis and matches this list with the records that providers send over. She said data will not be shared with the plans if patients are no longer active members.<br>  ○ John Hinesly this is a difference with encounter-based CCDs vs. patient-centric CCDs – the latter has less ability to trace back to the provider groups. He said there could be improvements in provider documentation of patient insurance information.<br>  ○ Liv said there could be an additional meeting focused on data privacy and security if there is greater interest in the topic.<br>• Adrian shared some of the challenges associated with the current data validation activities. He then shared the current approaches for PSV and measure validation. | |
| 4. DISCUSS POTENTIAL | • Adrian described various systemic issues (i.e., missing encounters, patients, encounter codes and clinical values; third-party code sets used in place of industry standard and custom mapping of data from practice EHRs to the QRS) and associated impact that affect PSV and measure validation. He offered potential resolutions for each issue and welcomed feedback from the Subgroup. | |

**Commented [KO(1]:** I don't recall him saying this so I can't proof this for accuracy… just FYI

| Agenda Item | Key Discussion Points | Next Steps |
|---|---|---|
| | ○ J Gates (in the chat) shared some potential solutions to the issues Adrian raised, including using raw claims de-duplicated with UDS reporting to identify qualifying encounters and attribution lists merged with MPI to identify missing patients. He acknowledged the likely ongoing need for using both flat files and CCDs.<br>▪ Liv said that EOHHS sends IMAT the Medicaid enrollment and MCO/AE attribution file, which we can use to explore pretty immediately whether this assists in uncovering gaps in patients sent to QRS.<br>○ John Hinesly asked if issues varied by EHR platforms and recommended triaging issues by EHR.<br>▪ Liv said the list of systemic issues tend to go across all EHRs. Some EHRs have specific issues that need to be addressed on a case-by-case basis.<br>○ Mark Marinello said Coastal has a greater percentage of attributed patients for which Coastal does not have data in its EMR for its United population (9%) compared to its NHP population. He added that Coastal does not have a good process for updating its attribution list to align with EMR data.<br>▪ Yajaira Almonte added that Coastal is trying to collaborate with United by sharing files every week, but United also cannot connect with these patients.<br>▪ Liv said this issue is out of scope for the ECDE Subgroup, but using the attribution file is a potential way to validate if a large portion of patients are missing in the data sent to QRS.<br>▪ Charlie Estabrook confirmed comments from the chat that AEs are responsible for cost and quality for all attributed lives. He said that he could further look into the attribution problem outside the context of this group.<br>▪ Stacey Aguiar shared that MCOs use EOHHS's attribution methodology to auto-assign patients to AEs. She said patients can be reattributed only if a) the patient requests a change, or b) if patients have a certain number of visits with another provider.<br>○ J Gates (in the chat) asked if it was possible to apply AI/ML to CCDs to 'correct' the measures and discover data that is obscured by formatting.<br>▪ John Hinesly (in the chat) said he did not think NCQA has approved use of AI/ML for HEDIS data at this time.<br>○ Dan McGuire (in the chat) noted that standardizing clinical documentation processes will be a non-trivial exercise.<br>▪ Liv agreed with Dan and asked for different ways to approach this work. She asked for which measures can standardization be expected (e.g., diabetes) vs. not (e.g., depression).<br>▪ Dan McGuire said PCHC is experiencing challenges because it does not have organization-wide clinical documentation standards, which leads to a misalignment in documentation standards internally. He noted the importance of creating internal standards first and then perhaps have mapping some data from the AEs to the QRS.<br>▪ John Hinesly shared that all encounter data must be transmitted before there can be any standardization processes. He added that the USCDI v3 standard will introduce | |

**Commented [DK2]:** This was his actual comment, in case my summary is incorrect:
Missing encounters? Raw claims de-duplicated with Health Center's UDS report of qualifying encounters? Missing patients? Attribution lists merged with MPI (RIQI probably has this). Medications should be qualified by Surescripts fill status if possible. Sadly, each EMR has annual shift in data lists - so flat files will be perennially necessary as CCD content is in the hands of the vendors.

**Commented [KO(3R2]:** I think your summary is good – all respect to Dr. Gates but he always has very ambitious suggestions 😊

**Commented [DK4]:** I think there's more nuance here that I missed.

| AGENDA ITEM | KEY DISCUSSION POINTS | NEXT STEPS |
|---|---|---|
| | more standards for SOGI data elements, which will assist in evaluating health disparities.<br>○ | |
| 5. NEXT STEPS | • Liv summarized that the next meeting will focus on what are reasonable expectations to build as part of an ongoing data validation process (e.g., missing encounter codes). She asked the Subgroup to consider what is worthwhile to prioritize or not prioritize as part of these expectations. | |

**Commented [DK5]:** Is this true? If so, can you elaborate on what this might entail?

**Commented [KO(6R5]:** I think it's more that V3 is introducing standards around SOGI data elements, which will help assessing health disparities, such as in the depression measure.