

Reasons for Data Gaps in the CQMs

DRAFT

- PATIENT
 - The patient fulfills some of the CQM standard requirements (e.g. A1c lab) outside of the current data flow captured by HealthTech Solutions.
 - Any A1Cs that are in the IHDE database will be sent as an extract.
 - There may be some labs that do not have connections with IHDE, e.g. LabCorp.
 - Labs resulted at point of care, such as finger stick A1C's.
 - The Patient fulfills some of the CQM standard requirements, but results captured may not be:
 - Extracted due to the data being in non-standard places within the EMR.
 - Interpreted appropriately due to coding, mapping, etc.
- ATTRIBUTION METHODOLOGY
 - Patients see a clinician that uses a diagnosis or billing code in error or a uses a valid, but “clinically grey” one-time code that puts the patient in to a denominator in error.
 - As an example, the one-time use of a diabetes ICD10 for an encounter that is not accurate, but the patient is now included in a Diabetes A1c measure.
 - Patients that are not being tracked for quality are included in the patient attribution file due to the patient attribution methodology, thus some patients may be included in numerators / denominators that are urgent care or (one-time care) patients.
- PATIENT MATCHING METHODOLOGY
 - A patient in an eligibility list or in a data feed from an EMR and the respective CQM attribute(s) (e.g. A1c lab result) are not matched correctly to list the patient as compliant for the measure. The data is available, but not matched correctly.
 - A CQM attribute is applied to an incorrect patient, a false positive for compliance.
- CLINICIAN
 - Clinician's patient care doesn't follow the CQM standard requirements – Genuine care gap.
 - Variation – Most care requirements are followed, but not all.
 - Clinicians provide proper care but do not record the data in the EMR at all.
 - Variation - Most are recorded in the EMR, but not all.
 - Clinicians provide proper care but do not record the data in the EMR using correct codes, data fields, etc.
 - Variation - Most are recorded properly, but not all.
- EMR
 - The EMR configured differently and uses non-required codes instead of the required code set (e.g. SNOMED, ICD10) that are recognized as qualifying measure attributes.
 - Integration from EMR to IHDE does not include all the data attributes needed for the CQM.
 - Variation – Most data elements are included but not enough to make it a valid measurement.
- IHDE
 - IHDE received the data but failed to send it on to HealthTech.
 - Due to mapping issues (not realizing the data is present).
- HealthTech
 - HealthTech received the data, but the CCD produced an error message and the Extract, Transform, Load (ETL) process failed so it could not be parsed.