DCF/DAC-Subcommittee Unique Constraint and Dimensional Logic Model Meeting

Date: 10/13/2020

Start Time: 10:00

End Time: 10:35

Attendees: Jonathan Hall, Tracey Fannon, Rich Power, Greg Nix, Jesse Lindsey, Mike Lupton, Joanne Szocinski, Diego Wartensleben, Jennifer Ramirez, Nathan McPherson, Danielle Downing, William Garcia, Victor Gaines, Johnny Guimaraes, Sharyn Dodrill, Beau Frierson, Katie Morrow, Matt Lightner, Roderick Harris, Steve Lord, Marco Delgado, Ryan Lavender, Jason Lee, Josh Botbol, Nydia Neris

Opening Remarks:

The dimensional model will have no impact on data being submitted, and it won't have an impact on anything being rejected. It is simply for DCF Headquarters reporting purposes.

Item
1. Composite keys to be used to match FASAMS Version 13 records to FASAMS version 14 records to prevent duplicate records in the DIM Model. a. Jesse Lindsey – I did send out the documents last Tuesday after our JAD and I did not receive any responses back. I was hoping if there were some recommendations that I would get an actual email, but I didn't get any, so I guess we'll just go ahead and open it up. Has everyone had a chance to review it that wanted to review it, and if so, did it look as expected? i. Jesse showed them the specific fields that would be used to match on a version 13 and a version 14 record. He explained the purpose for this is multidimensional – one is so we don't submit the same record twice in the event that it is accidentally submitted in version 13 and version 14; also a big part of it is making sure we have a continuity of a treatment episode across versions. That way we don't have arbitrary cut-offs for any treatment episode when it's not accurate. b. He opened the floor to everyone and asked everyone who had a comment to just let him know. i. Johnny – just for clarification, the client that's indicated here; is that the client SRI or is it something else? ii. Jesse clarified that Johnny was referring to the ClientKey is automatically assigned in the DV when submitted. That's an internal function of FASAMS. iii. Beau – we discussed on the JAD call removing DOB from the client because SSN or PseudoSSN have to be unique, so we do not want the DOB. iv. Jesse – you're right we did talk about that on the new constraint and I forgot to update it on this document. v. Sharyn – in the performance outcome measures the subcontract is only associated with an admission, there is no association with the performance measures. It comes up with FACT. Many of the FACT clients were

submitted under contracts long ago and aren't the current contract. If you're trying to pull the current data, it makes it difficult.

vi. Jesse – In this scenario, I believe the developer is going to be using the SubmittingEntity key that's assigned, which is kind of similar to the ClientKey, so it's an internal nonchanging even if the contract number changes. Based on submission and drilling down into how the XML parent/child relationship works, we would be able to get down to the POM. Maybe I can help with the ME IT group if you want me to join in on that; if that would be beneficial at all.

vii. Mike – Just a couple of things as we discussed, the admission date is one potential source of issue. Also, as Sharyn mentioned, contract number doesn't mean a thing, only the admission does. The only time a contract number really matters is on a service because that's when we link it back to are you contracted for this service and do you have a unit rate? Other than that, I have no idea when say Steve Lord goes to submit his clients who have been open since the 90's, what he's going to put as a contract number, and it may have absolutely nothing to do with anything that anybody anywhere knows.

viii. Jesse – so you think that contract number might change from the version 13 submission to the version 14 submission? Is that what I'm hearing?

ix. Mike – I don't think that any contract information is meaningful on an admission record. You know who the Submitting Entity is and you know who the Provider is, but you aren't going to have subcontract data defined from a time-period before the ME exists because there wasn't an ME subcontract, and it's unlikely you'll have a subcontract beyond what the current subcontract is with the Provider just because the older subcontracts don't really have those elements and I if we really need to, we can probably try to shoehorn them in, but I imagine that's going to be a mess too. So when you get the things with contract, subcontract that definitely gets you to a degree of fuzziness.

x. Jesse – I'll bring that up to the DEV Team. So, Sharyn and Mike it sounds like you're both saying the same thing – contracts could be problematic and maybe even subcontracts.

xi. Sharyn – I don't think we're quite saying the same thing. We both think it's going to be a problem, but the fact is, apparently SEFBN and BBHC are the only two MEs that actually do POMs at the contract level, subcontract level, and now we can't pull the data because we can't associate POMs with the correct contracts. The thing I disagree with Mike on is the only place the subcontract is important is me is the subcontracts.

xii. Jesse – I can give some direction on that. Sharyn, once you send that out, I can give some follow-up info.
xiii. Mike – a couple of other things; with the ProgramAreaCode, depending on the resolution with the ProgramAreaCode problem, that may or may not be something that you can use.
xiv. Jesse – Right, on treatment episode.
xv. Mike – yes, and then when you get down to the admission, I don't know that the ProviderSite is going to be all that useful for this. Again, thinking back to what you are likely to get from the admission coming from the Provider. It may be the same, it may not. It depends on what their older records actually say. I know from those older clients, when we brought them in, it was based off whatever the most recent outcome we had for a client was. The Provider may have something entirely different for the site when they go and do that initial load for those people. So, that may be problematic for you.
xvi. Jesse – Sites may not match between versions.
xvii. Mike – getting down into BedCapacity, I would think you would want to include FacilityType and AgeGroup to help uniquely identify those so then you can match across. Same general notion about contract and subcontract, and then for the Utilization you would probably also want to link back to the parent capacity record or if you're just flattening the structure, you could have again the FacilityType and AgeGroup so that way you make sure that you're getting the unique levels there.
xviii. Jesse – Thanks, Mike. Any other comments on it, recommendations? I'll take these back to the DEV Team and we'll look at them and then add in what looks correct.
xix. Mike – for the subcontract service, presumably you would want to have the CoveredService ProjectCode included in that, as well.
xx. Jesse – I agree. Good ideas. Does anyone else have any comments or is this one good to go?
xxi. Steve Lord – Can you explain to me why we would include SiteId at all? When I'm looking at creating unique keys and making sure that you're not getting duplicates, if you remove the SiteId, I guess I'm trying to look at where we might have duplicates or multiples based on SiteId.
xxii. Jesse – are you talking about in the immediate discharge area eval right here. Is that what you're talking about?
xxiii. Steve – yes, I'm trying to read through that. I'm sorry that's on an evaluation. I was thinking we were talking about admissions, but that's an evaluation.
xxiv. Jesse – right, and we do have it on admission right here, as well.

xxv. Steve – I guess I'm thinking that what's your unique values. It's going to be the agency and the admission date.

xxvi. Jesse – one of the things that we aren't including in here right now is ProgramAreaCode because there is a scenario I think in Beau's group where someone could be admitted to two different sites under different Program Areas, so this is the developers first hack at trying to identify. If you think that one should be looked at again, we certainly can.

xxvii. Diego – I think that will be the case with the treatment setting codes that were removed, right? That you would have the same admission, same date, same time, and the only thing that would change is the treatment setting code, and I would guess the ProviderSite wouldn't tell you that either. That they are not the same.

xxviii. Steve – Right, so that ProgramType or that TreatmentSettingCode does make sense, but I'm not sure what ProviderSite gains you.

xxix. Diego – I agree; ProviderSite shouldn't be part of it.

xxx. Jesse – Thanks, guys. We'll have a look at that and remove it. I'll also talk to the DEV Team to see why they thought it had been included initially, and we'll knock it out if it doesn't need to be in there. Any others? Thanks, everyone.

2. Unique Constraint
    a. Jesse – Now, we are going to have a similar discussion with the unique constraint, and I did make some updates to this. As I reviewed it a little more after I sent it out, I'm not sure I sent out the most recent copy. There's just a few changes to Waiting List and Acute Care. Diego, you started talking about this one before. Do you want to jump in?
        i. Diego – I have a couple of observations in the service event. In the client specific you have site identifier, right? Again, I don't that is something that should be there because I'm always thinking about double billing. So, you would allow the same service, starting at the same time, with the same covered service code and the only thing that would change is in the site identifier. It doesn't make sense to me. It looks like somebody is trying to bill the same service again under a different site.
        ii. Jesse – So, you're saying that if the CoveredServiceCode, HcpcsProcedureCode combination is already the same, but at a different site, that it shouldn't be in there anyway. Is that what I'm hearing?
        iii. Diego – Right, I would consider that a duplicate service and somebody is going to double bill.
        iv. Jesse – Are there any scenarios where someone can get the same service, but in two different sites? Where maybe one site is more technologically advanced?

v. A number of people responded, “not at the same time”.
vi. Diego – Another thing, if they’re not client specific I wouldn’t include the ExpenditureOCA, I would include a SiteId.
vii. Jesse – But CoveredServiceCode can stay in?
viii. Diego – yes, and I think that you should remove StartTime and the SiteIdentifier from client specific and add StartTime to and remove ServiceCountyAreaCode from Non-client specific.
ix. Beau – For us, when we are talking about a unique service, we’re usually talking about a unique client or a specific client by specific by specific staff done at a specific date and time with a specific procedure code. So, in the client specific rule, the one thing I don’t see there is staff. I don’t know if that even needs to be in there because of the other things we have to have. But, when we’re talking about a unique service, in the business line here anyways, we’re also talking about using in there. That’s what creates uniqueness for us.
x. Diego – But the question is, do you have two staff doing the same service for the same client and at the same time?
xi. Beau – Service, no. Actually same procedure code is theoretically possible. They could be doing two different assessments on the same appointment date and two different staff are doing those assessments.
xii. Diego – But that’s on client specific. How can a client be with two different persons at the same time?
xiii. Steve – You could have two different case managers working on the client at the same time.
xiv. Diego – The case management could be, but is it possible that they start at the same time?
xv. Steve – It’s possible. The EMR’s works on schedules. So, we could have two case managers, one is taking the client down to the SSI office for whatever reason, and another one has started working on housing. In our FMT Team, for example, we have a housing specialist and then a benefit specialist.
xvi. Diego – Wouldn’t you have another covered service code or another procedure code, or not?
xvii. Steve – No, it’s the same procedure code, you just bill a case management service.
xviii. Diego – If that’s possible, maybe we should add the staff identifier.
xix. Steve – Yes, I think the staff Id is important.
xx. Jonathan – Jesse, do we have a staff Id in the service event module that we could link it to?
xxi. Jesse – Yes, we do. Diego, you said ServiceCountyAreaCode should also be removed.
xxii. Diego – Yes, I think it should be removed. That’s my opinion. I think it’s the same as the SiteIdentifier.

xxiii. Jesse – Alright, that's good on client. Any other comments on client?

xxiv. Mike – This is more of a general thing, because it repeats throughout the Treatment Episode, as well, but where you have the episode SRI, you can look at the client specific service events since that's what we're looking at. But, where you're referring to the Treatment Episode SRI, we want to try in client situations where a provider, like say, something happens in their SRI generation process, and suddenly they're creating duplicate episodes with different SRI's and duplicate services. I don't think we want the episode SRI, for example, in this case. I think we want something back to like a client key. It's the client who isn't going to have multiple services at the same time. That's kind of what we are trying to get down to; to try and prevent. I have a glitch in my system, and I have added a string of characters to the end of all my SRI's and resubmit then you run into the situation where you've just duplicated all of your treatment episodes. Then if you use the episode SRI here it would allow them to duplicate all of the services. So, I think you want to just filter down to here's a client key and then use the other stuff to say and this is a unique service for that client.

xxv. Nathan – Just to add into that, we've talked about this a couple of times. One of the things that this is going to improve by having this idea of unique constraint composite keys, it's going to help us better identify uniqueness in the records, and I want us to get away from FASAMS being dependent on SRI's. The SRI's are an attribute of the record, but FASAMS shouldn't be dependent on that. So, if we put this in here then that may make FASAMS dependent on this SRI.

xxvi. Sharyn – Good point.

xxvii. Jesse – So, I've got the note in here, thanks Nathan, to look at getting back to the client identifier and the specific service event for the specific client identified, and not using the episode SRI. No problem, I'll look into that and see the best way to get to that spot. Thank you, both. It was also mentioned this is in Treatment Episode, as well. Is that right, with the client SRI?

xxviii. Mike – You want to keep the client. In some way, you need to uniquely identify a client, because you don't want a proliferation of episodes. We just want to make sure that if something happens and a provider's SRI process goes wrong, we don't want to recreate all of the same data. We want something to say hey, you know, this looks like the same client, the same program area, the same date, all of that – this is a problem.

xxix. Sharyn – Right, and I was just going to underscore that it would be better to use the client keys, not the SRI's,

because the SRI has just too many issues with it and it won't necessarily give you uniqueness.

xxx. Jesse – So, I think essentially, we can get away from all of the SRI's, which we're trying to do anyway, and figure out a different route wherever an SRI is used. I'll go through and look at what can be done for that. Any other recommendations in the unique constraint logic? I got some good info here.

xxxi. Mike – I just had a quick question about the functional document. The functional assessment that we were looking at. That was the other document that was shared and basically, it comes are to the CGAS score and I know there has been lots of conversation about exactly what's happening with the CGAS score, but at this point there isn't anything clear beyond we need it still. So, apparently in the proposed functionality we eliminate tool code 9, which is CGAS. If we haven't solidified what's happening with CGAS beyond that we need it, we should probably keep tool code 9 to make sure we're still getting the CGAS score.

xxxii. Jonathan – That's a communication mistake on my end, I guess. I didn't bring that up that CGAS was noted for elimination, but yes, we certainly want to keep that with the intent that it will be required for all children above the age of 5 in the mental health program area so that we make sure we actually get a CGAS score.

xxxiii. Sharyn – I thought that we had agreed to put in a separate field for that since it was required, and we were going to take out all the other functional assessments.

xxxiv. Jonathan – yes, that is the intent. The CGAS will remain and all the other functional assessments would come offline and we would just that general improvement score.

xxxv. Jesse – So, when we were going through this level of functioning, basically, I got the direction that all level of functioning would be expired on 2/1, but it sounds like we still need CGAS, so 9 would not be expired, but it won't be its own field, Sharyn, like you mentioned. It would still be the same tool code with the CGAS evaluation tool code. Does that make sense? We're not going to have an additional new field. I thought I heard you say that, so I want to make sure.

xxxvi. Sharyn – So, for level of functioning, we will no longer have FARS and CFARS; we're replacing that with uniform, whatever we're calling that, universal tool. So, they'll be two items – that and CGAS.

xxxvii. Jesse – That's right, exactly.

xxxviii. Sharyn – and both will be required. Is that correct?

xxxix. Jonathan – correct.

xl. Jesse – Is that a pare of it, Jonathan? Are they both going to be required at every submission? I don't have that in the document.
xli. Sharyn – It would almost have to be if they are both associated with POMs.
xlii. Jesse – Right, at this point I think the way it is stated is that at least one has to be, so if there's two, then it could be one or the other.
xliii. Jonathan – We would need both of them.
xliv. Sharyn – Yes, they're used differently. They're not comparable. One is used for SED and the other is used for improving performance.
xlv. Jesse – So the new rule would be CGAS must always be provided, as well as the new general functional tool code.
xlvi. Sharyn – Exactly.
xlvii. Jesse – Alright, I'll update the document with that. That was a good catch.
xlviii. Jonathan – Thank ya'll for catching that.
xlix. Jesse – I'll update it and get the new rule added and then send it around to DCF for final review and approval.
l. Jesse – Any other comments on these three enhancements? I'll get them updated and review them with the DEV Team.
li. Jesse – Thanks, everyone. Have a good day.