SEPTMEBER 2023 ECDE SUBGROUP MEETING

Thursday, September 7, 2022 (11:00 am – 12:00 pm)
Via Microsoft Teams

FACILITATOR: LIV KING, ADRIAN BISHOP AND KASH BASAVAPPA

AGENDA ITEM	KEY DISCUSSION POINTS	NEXT STEPS

1. TIMELINE FOR ALIGNING WITH USCDI STANDARDS	• Liv King welcomed the ECDE Subgroup and thanked the Subgroup for its participation to date. She then reviewed the meeting agenda.
	• Liv reviewed the ONC certification overview, specifically the 12/31/2023 requirement for EHRs to make available to customers the availability to export electronic health information in alignment with USCDI v1. She then summarized the first four versions of USCDI available to date.
	• Liv shared EOHHS' proposal to adopt a preferred standard for what AEs should use for a given performance year and a minimum set of standards in case AEs' EHRs are unable to comply with the preferred standard. The timeline would operate on a two-year cycle, with the preferred standard being USCDI v3 by July 1, 2025 and USCDI v5 (TBD) by July 1, 2027.
	  ○ J Gates, in the chat, said alignment with the USCDI standard makes sense as it is referred to in the Cures Act. He added that there will need to be use of flat files, possibly indefinitely, as AEs cannot force EHR vendors to take select actions. Liv agreed with J, noting that if EOHHS uses developmental measures that EHR vendors may not have programmed, it will accept use of supplemental flat files.
	• Liv indicated that this standard is applicable for all practices that meet the requirement for phasing out use of AE self-report for the AE quality program and encouraged AEs to be in regular communication with their EHR vendors about the required timeline. Liv specified that by July 1, 2025, the AE EHR vendors should at a minimum export data in adherence with USCDI v3 *or* USCDI v1 with a supplemental flat file. She noted that these deadlines align with the DAV certification cycle. She said the big difference from the status quo is that today EHR vendors may be using proprietary or homegrown codes that are challenging to integrate into the QRS.
	  ○ J Gates appreciated the effort to standardize data collection and transmission. He said EHR vendors may be able to format exports in alignment with USCDI but it may be more challenging for practices to populate the fields with the required data. He recommended adding language to clarify this requirement.	

2. TIMELINE FOR ADOPTING REVISED MEASURE DATA	• Liv summarized the discussion around *Screening for Depression and Follow-up Plan* and *SDOH Screening* from the August ECDE meeting. She shared EOHHS' proposal for how to collect data for the two measures electronically by July 1, 2025, i.e., the preferred deadline for transitioning to aligning with USCDI v3. For *Screening for Depression and Follow-up Plan*, AEs can begin to use LOINC codes to capture	• EOHHS will revisit the *Screening for Depression and Follow-up Plan*

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COLLECTION AND TRANSMISSION APPROACHES	depression screening information. For *SDOH Screening*, AEs can continue to use the homegrown Z codes. However, after July 1, 2025, AEs will no longer be able to use non-standard approaches or custom codes for either measure. ○ Dan McGuire, in the chat, said is a reasonable approach. ○ Andrea Galgay noted the OHIC Measure Alignment Work Group is convening to discuss the future of the depression screening measure and recommended ensuring that the work of the two groups is aligned. Specifically, if OHIC adopts use of the CMS measure in the future, which requires G codes instead of LOINC codes, then EOHHS should adopt the same approach. Deepti agreed with alignment across efforts and noted that both OHIC and EOHHS have signaled their preference to adopt the NCQA version of the measure in the future because it has greater specificity around what constitutes a positive screen and what is an eligible follow-up activity. ○ Andrea Galgay said an EHR vendor may have the functionality to meet the USCDI standard, but there is additional work required by the AEs to capture SDOH screening information electronically. She questioned the viability of the 2025 date. Adrian Bishop said it would be easier if AEs are using screening tools, such as PRAPARE, for which there are already established LOINC codes. Liv added that EOHHS will reconvene the ECDE Subgroup in spring 2024 to monitor progress towards the July 1, 2025 deadline. ○ J Gates said there needs to be a precise list of acceptable ICD-10 and SNOMED CT codes. Andrea Galgay shared that the NCQA version of this measure, which OHIC recently added as a developmental measure, lists all the LOINC codes by screening tool.	measure after OHIC convenes an additional subgroup on the measure. • EOHHS will monitor the feasibility of the 2025 timeline for the *SDOH Screening* measure.
3. DISCUSS FUTURE FUNCTIONALITY OF THE QRS	• Liv King reminded the Subgroup on the intended goals of the QRS. She summarized that in the past, AEs requested including measures that rely on claims data in the QRS and asked which measures would be helpful to include moving forward (e.g., adult immunization measures, *Eye Exam for Patients with Diabetes*, cancer screening measures). ○ Liv King and Tricia Stewart said MCOs currently receive immunization data on their members. These reports could also be produced for AEs. ○ Dan McGuire, in the chat, asked if the immunization data would be a duplicate of the bidirectional data that AEs receive from RICAIR. Liv said her understanding is that AEs have bidirectional data sharing with KIDSNET for child immunization data, but not for adult immunization data. ○ J Gates said if primary care practices don't receive consult notes from optometrists, AEs do not know if a patient has been examined for eye exams. MCOs can send gaps-in-care reports to AEs, but that requires manual data entry rather than an electronic data transmission. Dan McGuire added that all optometry providers do not use CPT II codes for this measure. Liv said EOHHS can look into the feasibility of providing these data to the AEs via the QRS. ○ Leigh Nyahe expressed her preference for adding measures to the QRS so that AEs can receive data in a timelier fashion. ○ Stacey Aguiar said United does provide data to AEs on a monthly basis, but the data may be limited to include only paid claims. Liv said that AEs could share these claims data with the QRS instead of MCOs.	• EOHHS will explore including immunization measures in the QRS before expanding to including claims-based measures. • Subgroup members should reach out to EOHHS if they are interested in pursuing any future developmental work.

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	○ J Gates said it does not help frontline physicians to have these data in the QRS if the data cannot integrate with an AE EMR to provide real-time updates during care delivery. Liv said she believes the issue lies with EHRs. Specifically, the QRS can provide conformant CCDs that go to MCOs on a monthly basis, which could also be shared with AEs. However, AE EHRs would need to be able to ingest that format. J said he would prefer receiving claims data, including unadjudicated claims, as soon as possible. ○ Liv proposed beginning with immunization measures before moving to claims-based measures. ○ Dan McGuire and Leigh Nyahe supported included cancer screening measures in the QRS. Dan confirmed that IMAT built the *Lead Screening in Children* measure in the QRS as well. • Liv shared some other potential ideas around future QRS functionality, including executive dashboards, FHIR/API enhancements, immunization reports and survey capabilities. She asked the Subgroup for its feedback. ○ Liv shared that the QRS does collect contact information on patients from various data sources. J Gates indicated that this information would be really valuable to help AEs reach the attributed but not seen population. ○ Dan McGuire said it would be helpful to have data on access to care so that AEs can better understand which patients have unmet needs and their characteristics (e.g., attributed children that are unable to receive a well-care visit due to limited availability of pediatricians).	
4. NEXT STEPS	• AEs should work with IMAT to complete this year's PSV/DAV cycle. Tricia Stewart thanked the AEs for being responsive during this year's process and indicated that it has been an easier lift for IMAT overall. Liv added that IMAT will be conducting year-round PSV moving forward. • EOHHS and IMAT will use feedback from the Subgroup to update relevant documentation and AE standards for PY7 around data collection and transmission. EOHHS is developing a website to house QRS documentation. • EOHHS will reconvene the ECDE Subgroup in spring 2024 to assess progress towards the July 1, 2025 deadline to align with USCDI v3 standards and troubleshoot any issues that may arise.	