APRIL 2023 ECDE SUBGROUP MEETING

Thursday, April 13, 2022 (1:00 pm – 2:00 pm)
Via Microsoft Teams

FACILITATOR: LIV KING AND BRE LEMIEUX

AGENDA ITEM	KEY DISCUSSION POINTS	NEXT STEPS
1. INTRODUCTION	• Liv King and Bre Lemieux introduced themselves, welcomed the Subgroup and reviewed the agenda.	
2. DISCUSS SUBGROUP CURRENT CHALLENGES AND GOALS	• Bre Lemieux described the goals and functionality of the QRS. She then reviewed two current challenges with ECDE and asked the Subgroup if there are other challenges they are facing. There were no additional comments. • Bre provided an overview of the questions the Subgroup will discuss over the coming meetings.	
3. REVIEW SUBGROUP MEETING PLAN	• Bre Lemieux reviewed the tentative agendas for the five meetings of the ECDE Subgroup.	

4. LESSONS LEARNED FROM DAV	• Liv King described the DAV program. She noted that NCQA requires use of CCDs for the output format in order to be considered a standard supplemental data source for HEDIS measures. Liv explained that in the absence of DAV, providers would still need to undergo manual chart reviews with health plans for HEDIS reporting, which is more burdensome than the DAV requirements. She added that there are additional data that are in the QRS that are not validated as part of the DAV certification process, such as supplemental data flat files.
	• Liv reviewed the differences between data fidelity (assessed through DAV) and data completeness. She then provided an overview of the 2021/2022 DAV cohort results, the DAV cluster list for 2023, the PSV process and common data quality issues.
	• Liv outlined example expectations that could result from the ECDE Subgroup, including: specifications for what should be included in a supplemental flat file, identification of a primary point of contract for PSV and a monthly enhanced data validation report.
	• Mark Marinello (in the chat) said it will be important to consider questions on HIPAA compliance and legal risk, specifically regarding the minimum necessary standard, when thinking about data fidelity and complete data.
	  ○ Liv noted this has come up in the past. She said this is one rationale for creating a specification for the data elements being requested for quality measurement and validation.
	  ○ Mark Marinello added that Coastal's work with IMAT has been productive and successful. He clarified that his comment was more about how many years of data to send to the QRS in part because of the churn in Medicaid.
		• EOHHS looked into how NCQA's CCD specification aligns with the USCDI standards. Currently, output CCDs from QRS are not USCDI conformant.
		• EOHHS will assess adding USCDI conformance to the roadmap and welcomes input from MCOs on expected value.

Agenda Item	Key Discussion Points	Next Steps
	○ Liv said EOHHS deferred to each AE's judgement for how much data to send. However, the QRS works better when AEs send data for all patients, in part because it's easier to maintain data over time. ○ Liv added that another idea EOHHS has is to build gaps in care reports using KIDSNET data that allow AEs to identify which screens children are missing. This, however, is contingent on AEs sharing data for all patients. • Jon Hinesly asked whether EOHHS is aligning with USCDI standards as they are updated or if NCQA is creating a separate way to structure data like they used to do with EQRM. He commented that the USCDI v1 was focused on standardization whereas v3 is focused on health equity. ○ Adrian Bishop indicated that no two EHRs are the same and they preexisted the 2015 CMS specifications that established SNOMED codes. As a result, EHRs tended to use unique code sets, some of which end up getting transmitted or incorrectly translated. ○ Liv King said she was unaware of how NCQA's guidelines align with USCDI standards but will look into it. Liv added that USCDI v3 does have new elements that EOHHS wants to support, but it is dependent on receiving data from the EHRs that would map to those output fields (e.g., SOGI data), because otherwise those output files would be blank. ○ Dan McGuire, in the chat, agreed with Liv and shared that Intergy does not send SOGI data at present. ○ Jon Hinesly said United is seeing standard CCDs being turned into custom flat files because EHR vendors are adding additional non-standard fields. ○ Liv said there will need to be a certain amount of customization that will need to happen, but EOHHS is striving to limit the amount of customization. ○ Adrian Bishop highlighted that IMAT has received ONC certification. • Andrea Galgay said Integra's biggest issue is around internal mapping, for example with LOINC codes. She said there will be a point where Integra will need to maintain a crosswalk, which seems daunting. ○ Liv noted that sometimes it is possible to include certain requirements in contracts with EHR vendors, but sometimes not – so some amount of mapping is likely to be inevitable. ○ Dan McGuire, in the chat, agreed that internal mapping is hard to maintain. ○ Mark Marinello said Coastal has the same challenge with LOINC codes. He said Coastal assumes that payers and/or IMAT will conduct the initial mapping, but that Coastal will maintain the crosswalk over time. ○ Adrian Bishop said it may be easiest to address this challenge though supplemental data files. ○ Liv recommended that the Subgroup first identify the ideal state first for ECDE. It can then assess what is missing from the ideal state and evaluate how far away individual AEs are from this standard. Dan McGuire supported this idea.	
5. Next steps	• Liv reviewed the agenda for the next meeting and asked the Subgroup to consider what is worthwhile to prioritize or not prioritize as part of these expectations.	

Commented [DK1]: When/where will this need to happen?

Commented [KO(2R1]: Each provider site / EHR combo is a little unique and sometimes they need customization to get the data fields populated that we want… it's just inevitable. The customization is in the interface & how and what data is sent to IMAT

Commented [DK3]: Is this right?

Commented [KO(4R3]: Yes

Commented [DK5]: Is this entire section accurate? I had a hard time following the conversation. Can you also explain why this is an issue with LOINC codes? I was under the assumption that LOINC were commonly accepted and frequently used codes.

Commented [KO(6R5]: They are but sometimes EHRs use proprietary third party code sets on the backend and they send those over instead of LOINC codes… or the quality measure is checking for a LOINC code, but the EHR doesn't produce one by default, so you have to map something to it.