Leadership Corner: A Conversation with Elaine Fontaine on ECDE Readiness and What Comes Next

We connected with Elaine Fontaine to reflect on what Rhode Island can learn from the national and regional ECDE landscape work and how those lessons translate into practical next steps for Accountable Entities (AEs) and practices. The conversation below focuses on what matters most now: where readiness starts, why quality reporting breaks down, and what Rhode Island can do to reduce burden while strengthening data quality.

Q **If you had to pick one "starter move" for AEs and practices, what should they do first to improve ECDE readiness?**

A Local data governance is foundational to success with EDCE. Practices need to understand their current state. Who owns data quality decisions? How are clinical codes mapped to quality measures? When was the last time the blood pressure and HbA1c data were traced through to reporting systems for validity? How does the practice identify discrepancies between internal reporting of quality measures and external reports of the same measures?

The most successful organizations interviewed have someone on the quality reporting team with a seat at the table when workflow and system configuration decisions are made. While that may be aspirational, at a minimum, practices can start by convening their clinical, IT, and quality staff quarterly to review one measure at a time, trace it from the clinical encounter through to what gets reported internally and externally, and document who's responsible for each step in the process. That visibility alone can often reveal hidden gaps amenable to improvement.

Q **In your interviews, what was the most common reason quality reporting breaks down, even when teams are trying to do the right thing?**

A The disconnect between EHR system configuration and downstream reporting was cited repeatedly by many interviewees. EHR systems designed and optimized for clinical workflow and billing often have quality reporting as an afterthought. For example, a provider carefully documents blood pressure control in the chart, but it's captured in a format that can't be extracted for quality measurement, or lab results are returned as scanned PDFs rather than discrete data.

Relatedly, EHR configuration changes to address these issues can be costly and time-consuming, and smaller practices have the least ability to influence their EHR vendor to fix them. And they often can't afford the interface fees or upgrades needed to correct the problem.

Q **What's one practical way Rhode Island can reduce burden on primary care through data sharing, without making the lift unrealistic for smaller practices?**

A Rhode Island has two high-leverage options. The first is a policy approach that would require laboratories and specialists to share data directly with the HIE as a condition of Medicaid participation. This could be done through provider contracting, regulation, or modifications to legislation. States like Connecticut and North Carolina have taken this approach, and it could dramatically reduce the burden on primary care providers while improving measurement accuracy. This option, however, does have potential political sensitivity and would therefore be a longer-term solution.

The second option is to provide financial support for the infrastructure practices needed to deliver high-quality data, such as EHR interface fees, vendor configuration work, and ongoing troubleshooting support. Wisconsin invested $8 million in practice infrastructure; Kansas and Connecticut provide hands-on technical assistance. Rhode Island could commit resources to help practices address concrete barriers, including vendor negotiations and system upgrades, without prescribing exactly how that support is delivered.