Hi; I’m Michael Barr, Executive Vice President for Quality Measurement and Research at NCQA. Joining me today are Emily Morden, NCQA’s Director of Electronic Measurement Strategy, and Ben Hamlin, NCQA’s Senior Research Informaticist. This is episode 4 of the webinar series. We’ve been proud that over the course of these 4 webinars, we’ve had over 6,600 registrants. Today we’re going to recap 2019’s important decisions and announcements about the future of HEDIS.
Michael Barr: I want to take care of the first part of this presentation and Emily’s going to talk about our Electronic Clinical Data Systems learning collaboratives. Ben Hamlin is going to talk about some evolving principles for measures in our conversations with CMS in the Office of the National Coordinator, the Digital Measurement Community. And fresh off the email, the latest
dates and update for the Digital Quality Summit for 2020. Roughly half of the people—49%—who have taken part in this series work for health plans. To you, the core HEDIS audience, we say welcome, or welcome back. We also thank the growing number of technology and government executives have joined us today. It’s been about 16% of our participants so far. We’re glad you’re here.
Michael Barr: We especially want to welcome the many people on today's call who are new to this series. About 43% of you are learning about these topics for the first time today, and we've been really encouraged about how many people have joined these series in episodes 2, 3 and 4—that is, after the series started. It's also good to see the number of people interested in these topics growing. Because we understand so many of you are seeing this information for the first time, we'll start with a thorough summary of our previous webinars. Some of you have attended those. For those of you who have attended, we think this would be a helpful reminder of what we've been talking about. And then of course we recommend looking at the prior webinars. They're on the website, at the address you see here, and with respect to today, we will post slides from today's episode as soon as today's event ends. We will post a recording of today's discussion in a few days. We'll post a transcript of today's talk in about a week.
Michael Barr: So, why are we here? Why are we talking about HEDIS, the future of HEDIS? Obviously, you know we’ve been around for quite a long time. I think you also know (Emily would acknowledge it) things are changing. They’re changing quickly. The environment around us about health care and public policy and so on is changing, as is the environment for quality measures, reporting and technology. And we’re trying to respond to this by adjusting our strategies and talking to you and having you give us feedback as part of that. It’s part of our ongoing effort to collect information and market research to inform what we do.
Michael Barr: What we want to do in terms of our strategy is improve the utility of HEDIS. We’ve done great over 30 years. We need to be around—and we want to be around—for a lot longer. And so, to involve the portfolio of measures and be responsive to the needs of the health care community environments and the different stakeholders is our goal. We also, of course, want to maintain the integrity of the measures throughout the health care system and have them be used across the health care system in ways they may not have been used previously because we’ve tended to be focused on health plans.
Michael Barr: We don't have all the answers and we are going to institute any changes we talk about gradually. It’s a process, not an event; collaboration, not commands. We also know that the ratings across the health system for the types of change we’re talking about varies in sort of a piecemeal way.
Michael Barr: Here we’ve got changes; they’re going to be gradual. And it’s very important you know that we’re evolving in this journey. You’ve seen and heard some of the old webinars so far. And we welcome your feedback today in the future.
Michael Barr: There are five main topics I’m going to cover today. It’s all about what you might call “the HEDIS infrastructure” or how HEDIS works; not about the content of the measures or what HEDIS evaluates. The five topics—add another one—Flexibility in Allowable Adjustments; Accuracy in Licensing and Certification; Digital Measures; Electronic Clinical Data Systems reporting; and our Schedule Change.

Allowable Adjustments
What? “What’s the vision?”

Adjust measures  Keep clinical intent  Use HEDIS at different levels of system

Michael Barr: For each of these, I’m going to talk about what you can do next. So, let’s talk about Allowable Adjustments. Here’s the “why.” We introduced Allowable Adjustments a year ago when we released HEDIS 2019. Now we know that people use their measures for multiple purposes, but don’t always maintain the integrity of the measures in doing so. Therefore, we developed Allowable Adjustments to help you adjust measures without changing the clinical intent.

Michael Barr: Allowable adjustments are also how you can now use HEDIS at different levels of the health care system and for purposes other than health plan reporting. For example, you can filter results by product lines, turn off enrollment criteria, but focus on a population subset. For example, a narrower age range or demographic within the original measure specifications.
Michael Barr:

Why should you care? What’s the SOA? Allowable adjustments help you use measures correctly while adhering to the underlying clinical guidance or evidence base. They allow you to have the freedom to use HEDIS measures prospectively within delivery systems to guide clinical interventions and close gaps in care. We also think this will help reduce the burden of measure collection and reporting. By explicitly defining Allowable Adjustments, we hope to limit the variation you and others (and we) see in measures and align core clinical concepts and definitions across practices and networks in health plans. In other words, everyone will be assessed on the same clinical concepts derived from the same evidence base.
Michael Barr: What's the next step? Think about how your users might want to adjust them for other uses. We encourage you to read details about Allowable Adjustments. They are at the end of each measure section in HEDIS 2020 Volume 2, which we released on July 1. And of course, as always, please contact us at My NCQA if you have any questions or need clarification.
Michael Barr: The next topic is Licensing and Certification. While Allowable Adjustments is expanding, the uses of HEDIS are expanding at different levels of the health care system. We need to ensure that the use of the measures is appropriate, that the results produced are accurate, and expand our licensing and measure certification efforts. HEDIS is NCQA’s intellectual property. And using HEDIS measure specifications requires a license agreement with NCQA. If you use HEDIS internally for quality improvement within your health plan or delivery system, we count that as noncommercial use. The standard license agreement in our store when you buy Volume 2 is all you need.
Michael Barr: If you are a health plan that uses internal software to report HEDIS, your software must be certified starting in 2021 for HEDIS results reported in 2022. Any software you use to calculate or report HEDIS measures or rates must have a separate HEDIS license and be certified by NCQA. To put it in another way, if you sell services or software that use these measures, you must first receive the NCQA Measure Certification to demonstrate that how you use the measures meets our standards.
Michael Barr: The point of Licensing and Certification is helping ensure these results are accurate, reliable and can be used for all the purposes you intend; most importantly, improving clinical care. Our priority is confirming that measured calculations are based on accurate measure specifications. Measure accuracy should be a priority, because value-based payment models use quality measurement results to direct billions of dollars of payments. It’s vital that all parties tied to these contracts trust the underlying calculations. So, by earning NCQA Measures Certification, organizations know that the information system is calculating the results of the industry’s most rigorous assessment. This also means that everyone involved can value this contract and can have confidence in apples-to-apples comparability in different organizations’ HEDIS results.

Michael Barr: Consider how you use HEDIS. If you use HEDIS for internal quality improvement and noncommercial use, [the] license you get through the store when you buy Volume 2 is all you need. If your use is anything other than this, go to My NCQA, look for the Custom License Agreement link under “Ask Question” and “Orders.” NCQA staff will work with you on an agreement for Licensing and Certification.
Michael Barr: All right, moving on to Digital Measures: What do we mean? What’s the vision? What are Digital Measures? Right now, I’m talking about digitalized versions of existing HEDIS measures. Many plans currently report using the traditional methodology. This contrasts with Electronic Clinical Data Systems reporting or measures which are also digital but report differently—and I’ll talk about that in a few minutes. So, back to the current measures; traditional measures for which we provide digital specifications. In October, we released eight HEDIS 2020 digital measures for traditional reporting. These are machine readable and downloadable from the NCQA store.
Michael Barr: Digitalization means that NCQA writes measures as computer code so you don’t have to. It eases the need for you to read, interpret and read code measures and that will hopefully avoid human error and non-standardization. Our digital measures follow industry standards so HEDIS is easier to implement across the continuum of care. That consistency means providers measuring themselves use the same clinical constructs and then reporting HEDIS results to health plans. For those watching today who are more technology oriented, you’ll be interested to know that we currently use the quality data model, CQL, or Clinical Quality Language, is the logic that ties together elements inside the data model.

Michael Barr: We are exploring additional industry standards such as FHIR, Fast Healthcare Interoperability Resources to ensure measures remain aligned with others in the quality of measurements. Although we have a question for you in a couple of slides, to ask you about your state of readiness for some of those things.

Michael Barr: Right now, NCQA is the most watched video 2019 on YouTube, our website or other platforms. Introduction to Digital Measures summarizes digital measures in under four minutes. (We’re going to try to show it to you via WebEx.)
Michael Barr: I understand some of you may have had some difficulty listening to the video. It is posted on our website and we will send a link out to folks after the webinar if you would like to see that. The link is right at the top of the screen, ncqa.org/digital-hedis-video.

Michael Barr: Now I’m going to try something new, also. We’re going to ask you to respond to a poll about your readiness for Fast Healthcare Interoperability Resources, or FHIR. Start the poll, please.

Michael Barr: I’m told the poll is working. We’re going to give it a few seconds for you to respond and I will share the results. The questions are, what is your current level of FHIR understanding? What’s that? “I’ve heard of it before,” it’s choice A. B is “starting to know my way around.” C is “I’ve used it and [am] fairly comfortable.” D is “have done a few implementations, taught others, worked on implementation guidelines.” We got the results. “What’s that?” is 61% of the results. “Starting to know my way around” is 31%—a vast majority, folks. “I don’t know much about FHIR” is important. Because one of the things we’re talking about is why should NCQA use FHIR as part of our standards. All right, thank you. That was very informative.
Michael Barr: Okay, so let's move on to Electronic Clinical Data Systems reporting; try to explain that. Measures using Electronic Clinical Data Systems, or ECDS measures, are a subset of the NCQA digital measures portfolio. All ECDS measures are digital, but not all digital measures are Electronic Clinical Data Systems measures. The reporting methodology is part of the differentiation. Also, ECDS measures rely more extensively on how data that clinicians and patients generate is delivered. Data report in four categories; for ECDS measures [it] will be according to their source: in EHRs, registries or Health Information Exchanges, case management systems and administrative files.
Michael Barr: This chart shows the relationship between ECDS measures and regular Digital Measures and traditional measures for which we’ve added digital specifications. The important part is that these are all HEDIS measures. And the main takeaway is secondarily that ECDS measures all digital, but now all digital measures are ECDS.

Leverages more and better data into greater insight

Fosters patient-centered care
Michael Barr: ECDS brings all the efficiencies of the digital measures I mentioned a few minutes ago and quality measurement towards greater use of electronic clinical data. ECDS measures encourage use of clinical information from many sources, not just from EHRs. But because we anticipate more clinical data will become available over time, we believe ECDS is the future of clinical measurement. It combines claims data with data from EHR, Health Information Exchanges and other electronic sources, so it can provide more complete results and better insight into the quality of the care being delivered to individuals and groups.

Michael Barr: For example, the breast cancer screening measure we currently have specifies an age range as inclusions. It does not account for risk profiles or tissue preferences very well. Any ECDS measure could include all the logic associated with clinical guidelines. You can ensure, with one measure, that women get the screening appropriate to their unique clinical conditions and needs and preferences. Medicine is moving toward more customized clinical guidelines. And our view of the future is for measurement to reflect that.

**ECDS Reporting**

*Now What? “What’s my next step?”*

- Order ECDS measures: (store.ncqa.org/ECDS)
- Report ECDS measures
- Share experiences about ECDS reporting

Michael Barr: Now, we know several health plans already have connections to electronic health records, use data aggregator, the Health Information Exchanges, immunization registries and case management systems to support HEDIS reporting. And that’s going to help you as you segue into ECDS reporting. We also know many plans are trying to build these connections. They may only be able to access data for parts of the network. That’s why we are collaborating with plans to understand their
experiences with these ECDS: We want to hear from others. And one of the reasons why ECDS measures are voluntary.

Michael Barr: We invite you to report the 11 ECDS measures for voluntary reporting that we released in July. Among those are 3 existing HEDIS measures to which we added ECDS reporting: Breast Cancer Screening, Colorectal Cancer Screening and Follow Up Care for Children Prescribed ADHD Medication. We’re particularly interested in having health plans report these measures. We have both traditional and ECDS methodologies to inform our strategy.

First ECDS measure to be publicly reported

Prenatal Immunization Status

HEDIS MEASUREMENT YEAR 2020
(Reported June 2021)

Michael Barr: Now, some of you may have heard that in September, Prenatal Immunization Status met our criteria for public reporting for the 2018 measurement year. Many plans reported this measure and performance rates varied and reflected the expected rates evaluated by our analysis team and advisory panel. So, we see this measure as being ready now for public reporting. However, to give plans more notice, we announced in September that the measure will be publicly reported in 2021, which will reflect data for measurements year 2020.
Michael Barr: This next slide shows an artist’s rendition of our new online report cards, which will highlight plans that report ECDS measures. This report card launches in September of 2020. We’re adding this feature to our display because we want to acknowledge health plans that are taking the important step of reporting ECDS measures. The image on the left shows that visitors to our website will be able to create or isolate lists of plans who report ECDS. On the right, the image shows plans that report ECDS report cards next to plans that do not. The ECDS reporting plan will have the extra blue emblem or icon next to its name or with the explanation of why ECDS reporting is why it matters.
Michael Barr: Now for the last topic; a change that I’m going to cover: A change of the HEDIS schedule. What’s the big idea? We’re changing when we specify the measures that apply to a measurement here. Let me show you what I mean. Our traditional schedule is to release the measure specs in HEDIS Volume 2 halfway through the year in which the specs are to be used. For example, the measures we released in July 2019, applied to services this entire calendar year of January 1 to December 31, 2019.
Michael Barr: That means that the measurement year is half over before plans know what they’re expected to report. The six-month lag has been a feature of the HEDIS cycle for decades and we think we can do better. Now I’ll explain the new way. On August 1, 2021, we will release measures. These measures will apply to services in 2022. Health plans will have a five-month lead time on what measures will be.
Michael Barr: Why does this matter? We’ll get them 11 months sooner. Now the other thing we’re doing is while we’re shifting the HEDIS schedule, we’re also looking for ways to simplify the naming convention. The word “year” can mean these five things that connect with HEDIS. So, let me tell you what
we’re doing. Starting in calendar year 2020, the HEDIS Volume will be named under the measurement year.

### Schedule Change

**Now What? “What’s the next step?”**

**Transition Year: Two HEDIS editions coming July 1, 2020.**

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Michael Barr: This table shows how various parts of the annual HEDIS cycle will evolve. There’s a lot of information on this slide, and we know it will appeal to auditors and others of specific roles in the HEDIS process. So, when you download these slides from a website or watch the recording, go on and study these dates. But here is the most important date that affects everyone who’s watching. On July 1, 2020, we will publish measures that will apply to measurement years 2020 and 2021. This will be the transition year.

Michael Barr: And now we’re going to attempt another cool poll to gather your feedback about what topics you’re most interested to learn more about on an upcoming future HEDIS webinar in 2020. You have six choices; click on the three dots to access the poll.
Michael Barr: We’re really interested to hear from you because this will help guide what we do next in terms of setting up the webinars for next year. Some of the high-interest topics we’ve heard before were Digital Measures, ECDS, and Schedule Changes. And then less interest in Allowable Adjustments and Licensing. So, I’m interested to see how this group feels about the topics. Then, of course, during the Q&A, we’d love to hear about any other topics that we have not covered.

Michael Barr: Looks like Digital Measures and ECDS lead the pack here, with Allowable Adjustments and Schedule Changes coming in somewhat distant second place. Then Licensing farther down. We know there’s additional clarity to be had about the Digital Measures. And now you’ve given us motivation to continue to plug away at trying to define these and illustrate how they work and why they’re going to be the future of measurement. So, I appreciate your patience. I know we had some technical glitches during this first part of the webinar, but now I promise you the next set of webinar presentation will be seamless. We’re going to Emily Morden, who’s going to start doing the slides and talk about learning collaboratives with Electronic Clinical Data Systems. Over to you, Emily.
Emily Morden: Thank you, Michael. My name is Emily Morden. I’m pleased to share with you all today some findings from our learning collaboratives with ECDS measures. As we just discussed, we know that ECDS measures and reporting these measures is a new endeavor for many folks. And we also know that our behavioral health ECDS measures are important and can identify significant care gaps that we know are there in terms of screening and follow up and management for behavioral health conditions. So that’s why we’re excited about these two ongoing learning collaboratives that we have, where we’re working with health plans to both report the ECDS measures and do quality improvement. The Alcohol Learning Collaborative is funded by CDC and SAMHSA. It includes participation by three health plans from around the country.
Emily Morden: Our NCINQ Adolescent Depression Collaborative, which is funded by AHRQ and CMS, involves five health plans from around the country. So again, these are ongoing efforts. But we have started to learn some things through the participation of these health plans and we wanted to share some of the lessons learned so far with you all today. First, I’ll outline the target measures that we’re focused on. The target measures that we’re focused on in the collaboratives include one measure that looks at unhealthy alcohol use screening and follow-up. And then we have our suite of three depression care measures that look at population screening and follow-up for depression, a measure that looks at routine monitoring of symptoms using the PHQ-9 and then an outcome measure that looks at improvement in symptoms.

Emily Morden: All these measures again are specified for our Electronic Clinical Data Systems reporting method. And as such, the health plans working on these measures are collecting data from various sources to accurately assess performance on measures. So, they’re gathering clinical data that’s needed to see the results of a behavioral health screening or routine monitoring using PHQ-9, and they’re finding this data in electronic health records, data exchanges and other registries, as well as case management records.
Emily Morden: So, what have we learned so far in terms of the facilitators and the barriers to collecting these measures and making improvements on them? Well, in terms of the facilitators at the top here, we have found that getting stakeholders engaged is really a key piece. And this includes working with providers who are on the front lines providing care. And when we’re talking about doing these behavioral health assessments, oftentimes there’s a need to engage front desk staff, medical assistants in addition to primary care providers or behavioral health specialists. So, engaging those key stakeholders is important.

Emily Morden: Secondly, having a project champion is helpful to continue doing this hard work and keep things moving forward. And, to get leadership support and the needed resources for the project. And lastly, thinking how we can connect work on these measures to larger strategic efforts or the other screening efforts and interventions that a health plan is working with providers on. We also have found that to be a facilitator. Now, in terms of challenges and barriers, one of the key challenges that we’ve seen is that plans still do have limited access to that clinical data that’s needed to calculate the measures.

Emily Morden: And so, there’s a lot of work still to be done in being able to get that clinical data flowing for these measures. Now we’re also seeing that in many places, there’s still lack of integration; particularly with behavioral health in other physical health [care] settings. And this can really impact being able to do proper follow-up and management of conditions when we still have this lack of integration. And then lastly, just the stigma that we find with behavioral health conditions in general. This can really...
impact care-seeking behavior. And so, doing things like education with patients and providers can be critical to overcome that.

Which Interventions have Plans Found to be Helpful?

Strategies for Improvement

Access to Data
- Leverage health information exchanges
- Incentivize provider reporting
- Partner with provider groups to exchange data
- Incorporate LOINC codes into provider EHRs
- Work with data vendors

Increase Screening
- Educate providers on use of standardized tools and coding terminology
- Incorporate screenings into clinical workflow
- Use apps to engage patients

Follow-Up and Management
- Educate and train providers on evidence-based care
- Develop workflows for follow-up/management
- Outreach to members with positive screening and/or diagnosis
- Utilize case management resources

Emily Morden: I wanted to cover some of the specific interventions that the plans have found helpful in making improvements. As I mentioned, access to data is the key piece that we’ve been working on, and the plans and our collaboratives have been looking to leverage data from exchanges, have worked to incentivize data sharing with providers and partnering with different provider groups to exchange data. They’ve also done a lot of work to incorporate LOINC codes, which are needed to identify specific behavioral health assessments and the results of those assessments and having those incorporated into provider EHR systems and other data systems.

Emily Morden: Now, in terms of making improvements on the actual performance measures, we’ve seen the plans doing a lot of work around educating providers in terms of using standardized screening tools—and again, coding correctly; and, just incorporating these screenings and assessments into the clinical workflow has been key. In terms of follow-up and management, again, doing that education with providers on evidence-based care, developing workflows to help ensure that follow-up and management can take place, and then also figuring out how to outreach and engage the health plan members that have positive screening findings or end up with a diagnosis of one of these conditions. So, a lot of great work by the plans in our collaboratives to find out what works.
Emily Morden: I just wanted to drill a little bit deeper on this piece about access to clinical data and share a bit of experience from one of the health plans in our collaborative, AmeriHealth Caritas, in the District of Columbia. They’ve been working for about five years now to try and increase their collection of electronic clinical data from EHRs. And so, this effort is really supporting getting that clinical data that’s important to understand gaps in care and make improvements.

Emily Morden: And of course, with the work on the depression ECDS measures, they were also able to start exploring other clinical data sources like case management programs, and the Health Information Exchanges in their region. What have they found so far? Well, first, they found that really focusing their efforts on those practices and Exchanges, where the bulk of their health plan membership was being served, really allowed them to get the biggest bang for their buck in terms of getting that relevant data.

Emily Morden: Secondly, they found that incorporating data exchange with practices into the value-based payment arrangements that they had with those practices was a great way to incentivize the exchange of data. In terms of transforming this data collection process into something that’s more automatic, that’s something they’ve done a lot of work on and it takes time and resources to devote to that. But [it’s] worth the effort to do that transformation in your systems.

Emily Morden: And then lastly, providing relevant data back to clinicians. This was a really great way for the health plan to get buy-in from their clinicians and share back important information on the health plan members that could
help that provider in terms of doing care management for their patients.
We do have the full podcast available on our website at the link here, if
you’d like to hear from AmeriHealth themselves, sharing their experiences
about collecting clinical data.

What’s Ahead for 2020

Collecting and Reporting Measures

• Reporting the behavioral health ECDS measures for HEDIS 2020

Quality Improvement Resources/Tools

• Develop guide for reporting ECDS measures:
  o Addressing barriers/challenges
  o Using data collection tools
  o Balancing & interim measures to track performance
• Identify best practices and resources for improving care
• Case studies describing successful changes

Emily Morden: I’ll just wrap up with what’s ahead for 2020. Of course, we have continued
collection and reporting of the behavioral health ECDS measures. But
we’re excited to start harvesting some of these findings from our
collaborative and put together some resources and tools that could be
used for others that are looking to make improvements either in trying to
report ECDS measures or doing quality improvement on these measures.
So, we’re looking to develop a guide for reporting ECDS measures—
identify best practices that can be used to improve care and highlight
some more case studies from the health plans that we’re working with in
our collaborative.

Emily Morden: I just wanted to share with you some of these early findings; stay tuned
for more news in the future on other resources and findings that we must
share coming out of these efforts. I think I’ll turn it to Ben Hamlin now.
Ben Hamlin: Thank you, Emily. I’m going to go very quickly through what’s next. We had a lot of successes with our early implementation of ECDS and we’ve been working to help define a digital measure future and what that might look like. We’ve been working on a set of principles for what that should look like, with CMS and ONC to really help define a comprehensive and meaningful national measurement strategy.
Ben Hamlin: First we’ve always been trying to understand how to reduce the burden of measurement and how we should really think about this. And some of the ideas we’ve come up with for the roadmap include using data that’s generated during care and not continuing to impose additional requirements on top of those data requirements specific to quality measurement. Harmonization of measures across programs. Using common measures across programs. Using the same specifications instead of having a different version of each specifications for each different program, which just results in a proliferation of measures across the entire ecosystem.

Ben Hamlin: Again, thinking about common measure sets or measure sets for the different types of providers and how we can deploy those across all providers in these networks, as opposed to having customized sets for each individual instance, which just creates more mayhem.
Ben Hamlin: Most importantly, as we’re expanding the data that we intend to access to do these quality assessments, we really must ensure that the validity and quality of this data is maintained and improved upon. Of the process is particularly important as we start to obtain more granular information on everyone. We're looking for a lot more information on people to help us understand the quality of care they're receiving as it's being delivered across different care types and different locations for their data. It’s important that we have very transparent, consistent and valid ways to not only assess the data, but to utilize it most efficiently for our purpose, which is quality measurement and, ultimately, quality improvement.
Ben Hamlin: Since HEDIS is a national program, we've been talking to our colleagues at ONC and CMS about how to deploy this kind of program on a national scale. We must find ways to help deploy this in areas that may not have the same kind of resources that everybody does. And there are differences in terms of ability to access information, to understand this information, to deploy technology, to locate this information. And so, we've been working to help identify those areas where ONC and CMS—and even NCQA, through our programs—can help establish this kind of infrastructure to create more data exchange. To create better quality improvement strategies from quality measurement, and so on and so forth.
Ben Hamlin: Most importantly, we must ensure that everything we’re doing is still based on those national guidelines that inform our measures that inform what we should be doing at the point of care. And everything really needs to be focused on supporting quality improvement. We want to ensure that we’re fair with our comparisons in terms of how we’re looking at these different results and its different information. And again, always thinking about a continuous process of improvement through measurement and reassessment and improvement and reassessment and improvement.
Ben Hamlin: As part of that process we’re making sure that we’re not inadvertently creating disadvantaged populations or providers by deploying new measurement strategies. We must ensure that as we’re getting down to a person-specific level, we’re not disenfranchising or alienating certain populations because of the procedures we’re deploying for this type of measurement.
Ben Hamlin: We want to make sure that everything we’re doing is very transparent to those interested in QI, but also those who are interested at the policy level. To understand how to use this information for value-based care, how it can support informed decisions, accommodate social determinants of health and particular patients’ preferences—are all very important to the future strategy because it’s critical to understand the specific situations of what’s affecting the quality of care a person is receiving or the kind of care they need. These are sometimes separate from the current characteristics, but again, we can ensure that the measurement strategies we’re imposing on people are not introducing more burden and not disadvantaging specific populations and having other unintended consequences.
Ben Hamlin: And finally, we’re really trying to shift quality measurement to be much more prospective. To do that, we must really think about how this information can be used appropriately, but also when the information could become available. We don’t want to produce information willy-nilly or too quickly, [which would] create new problems in terms of the kind of feedback loop. We do want to make sure that we are getting this information where it’s needed, when it’s needed, to have the greatest effect. How we do this and how transparent each step of the way is, is important to us in this future-thinking strategy.
Ben Hamlin: So how do we go about doing this and how do we engage our stakeholders in doing this? We’ve had, as Emily has pointed out, several successes in terms of collaborations with our stakeholders and other customers to understand how to deploy the new strategies. But we’re taking this to the next level.

Digital Measurement Community

Coming Soon!

A NEW interactive platform for stakeholders engaged in the development and implementation of digital quality measures

To sign up, visit: www.ncqa.org/dmc or email digital.measures@ncqa.org
A New Interactive Digital Measurement Community
Addressing Knowledge Barriers and Lack of Coordination Across Disciplines

The Digital Measurement Community will foster collaboration around three primary areas of high impact and value:

- **Sharing Best Practices**
  To promote quality and accountability in the field
- **Education**
  To facilitate the adoption of digital measures and related standards
- **Collaboration**
  Collaborating to build a vibrant digital measurement community

Ben Hamlin: We will be deploying an interactive platform for all stakeholders to be engaged in these various processes. We’re going to make this customized to facilitate direction of this information to those peer groups that we think you belong in—but really encourage conversations between peer groups to disseminate best practices and facilitate communication of these new strategies.

Ben Hamlin: They are complicated. They are technical. But we think they have high value to just about everybody across the entire measurement spectrum. And so, we want to find a way to really encourage collaboration, but also a lot more communication across these different silos of quality that currently exist.
Digital Quality Summit

The Digital Quality Summit has grown quickly
Registrations 2017-2019

- 2017: 154
- 2018: 277
- 2019: 418
Ben Hamlin: We’ve had a lot of success in doing this in our annual Digital Quality Summit. We are moving on to our fourth iteration of the Digital Quality Summit. You can see here we started out in 2017 with a very small group of folks—“small” being about 150—which has quickly grown to a much larger group of folks. We’re trying to use this forum to encourage communication across the different silos in the quality realm, if you will. We’ve seen a great mix of folks come to this event. We’re hoping that this next event, which has generated resources like this white paper, where the states last year sat around a table [and] talked about their issues [and] their innovative strategies.
Ben Hamlin: This event is only three days long, so, if you come up with an entire roadmap and recommendations in three days—especially when starting from ground zero—we find that to be very exciting. This is why this summit is becoming so popular. For 2020, save these dates. July 22 to 24, it’ll be held in Arlington, Virginia, just across the river from us.

Ben Hamlin: It’ll be a fantastic event. It’s going to be very hands-on. It’s going to be very collaborative. It’s going to be very cross-functional. So, we’re going to be looking for how to message these new strategies, how to engage our new stakeholders and how to really find out what we can do—as a quality organization—to support our customers and our stakeholders. Getting to this wonderful new paradigm, which is ECDS, and which is the next generation of quality.
Questions

How to ask questions after today’s Q&A

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Login with Single Sign In
Andy Reynolds: Hi, everyone. This is Andy Reynolds. I'm Assistant Vice President for External Relations. I will now move us to the Q&A session. I also want to thank our colleagues at WebEx, who have allowed us to go a little past the 5:00 Eastern Time when we were scheduled to end, since we did lose a few minutes with technical difficulties. We're going to go into overtime. So, after today’s event, we invite you to ask questions. Many of you will recognize this process, and that is to use the PCS System. As for how to submit a question right now, you probably already have seen the Q&A window. Please do use it and I will get to some of the questions that people on the phone have already submitted.

Andy Reynolds: The first question—first two, in fact—ask us to back up to show a few things; specifically, the schedule and the video. So, here is the schedule. As Michael mentioned, the key dates are circled in red. These slides will be available on the site immediately after this event. And, in fact, all the previous webinar materials that you can also get at ncqa.org show this same slide. I’m also going to back up because someone else asked for another look at the video.

Michael Barr: Are we going to be replaying, Andy?

Andy Reynolds: No, we’re not going to replay the video. We’re just showing where to find the video. And that is the URL that you see at the top of that screen, ncqa.org/digital-hedis-video. Other questions that have been submitted: Please clarify how the five topics Dr. Barr covered relate to the benefits that have been mentioned. Burden reduction, accuracy and measuring
things that matter. In other words, do all five topics support burden
reduction, accuracy and measures that matter in the same way.

Michael Barr: I think they do relate in different ways. I think that was a great question
because Allowable Adjustments allow you to use the same measures that
cross the different systems and measure the same way you use the same
clinical logic, same specifications, but take out the attribution model. So,
from a perspective of what measures should I use at a clinician or
practice level, network level, health plan level, HEDIS is now usable
across those different ways.

Michael Barr: Licensing and certification pretty much speaks for itself in terms of
reducing the variability to making sure how you use them as accurate.
And the digital measurements, depending upon the readiness of the
system in which you’re working and the vendors you work with, and so
on, could be solving some problems in terms of time and effort. Now
you’ve heard there’s a white paper that’s also available, that talks about
the time savings that one health plan was able to save in terms of
implementing Digital Measures. Where previously [it] would take 50 to
100 hours per measure to manually program, they were able to
implement all 11 within less than 5 days and run them against a data set
of produce measure results. In a controlled environment, just to be very
clear, but the time savings is real in terms of implementation.

Michael Barr: Then, of course, certification. Make sure that you’re accurately
implementing and producing the correct measures. So, there are a variety
of different ways. This is the foundation for the future of measures. Once
we’re able to specify measures in the clinical logic in ways that we can
now, the kinds of measures and the burden associated with those
measures would be very different. Much less. And lastly, get to more
clinically relevant measures. We’re talking about several years. These are
building blocks here.

Andy Reynolds: Next question has to do with ECDS measures. Can you say more about
the difference between digital measures that are just digital and the digital
measures that are also ECDS? It sounds like ECDS is digital measures
on steroids.

Ben Hamlin: That’s an interesting way to put it. Yes. So, you must understand that
ECDS, like other domains in HEDIS, including our Effectiveness of Care
set, is not just about the measures themselves, but [about] the reporting
requirements, the program requirements, the data rules and everything
else wrapped up. So ECDS are in fact digital measures and they are
probably on steroids. I mean they are complex measures that require that
digital specification in order to really function well because they’re so
complex and they’re so involved. But they are in fact part of our digital
measure portfolio.
Ben Hamlin: So, we have 8 digital versions of traditional HEDIS measures that are the Administrative Specifications, expressed in a digital format. And we have 11 ECDS measures, which are digital measures that follow the ECDS rules for reporting. That’s the main difference. So, a digital measure is a type of measure, just like [a] paper [measure] is a type of measure. ECDS is an ecosystem for measurement that uses digital measures but it’s a whole different ballgame, if you will, in terms of quality measures.

Michael Barr: So, Ben, I think it’s safe to say we’re leveraging very similar data sets for both. Because I think that’s another misunderstanding in terms of the differences in the data. Could you explain that a little bit?

Ben Hamlin: Sure. the ECDS data rules and the data reporting requirements were built off existing HEDIS protocols. We developed this domain since we knew a lot of plans were trying to access a lot of these different clinical data sources or case management data to include them in their HEDIS reports. It’s just how many ways we were inhibiting a lot of the use of this data because we didn’t have good rules—or really, standardized rules or requirements—around this. The whole architecture of ECDS has developed to try and not only encourage more use of this data, but more standardized use of this data.

Ben Hamlin: We wanted to provide a way to better utilize this information and not have to have it translated through three different systems before it came from the point of care to ECDS reports. So, again, trying to encourage the standardization upfront and allow the measure to just activate that so the metric could be run before the end of the year, essentially.

Andy Reynolds: Are ECDS measures only available for depression and substance abuse-related metrics?

Ben Hamlin: No; we have a wider portfolio now. We have three measures in our depression suite. We have one Unhealthy Alcohol use measure and we have several immunization measures, one for adult immunization status and one for perinatal immunization status. As you saw, the Perinatal Immunization measure was set to go to public reporting status in 2021.

Andy Reynolds: If digital measures are the future of HEDIS, what is the future of the HEDIS Software Certification Program?

Ben Hamlin: Well, I think that we have two certifications right now: one for e-measures that NCQA certified vendors do and one for HEDIS vendors. Since ECDS is using a lot of the same type of data that you would find used for e-measures, namely, EHR data, I think one of our initiatives is to help try to eventually move those two programs closer together since they’re encroaching on each other’s territory. There’s always going to be a need for us to certify vendors or plans who are trying to calculate the quality measures, because it’s essential that we ensure that the processing of
this information that’s used for quality assessment is consistent, valid and reliable.

Ben Hamlin: The only way to do that is through our Comprehensive Certification Programs. So, the role of the vendors doing HEDIS in the future may change. How we certify our vendors may change. We may enhance our certification programs 10-fold in order to accommodate this new environment. But again, these are the things we’re doing on an intuitive basis with our customers to understanding what their needs are against what our needs are. To get that accurate data in-house.

Andy Reynolds: What is the relationship between the five topics that Dr. Barr covered and the seven principles that Dr Hamlin outlined? What are we talking about for the government?

Michael Barr: Great question. And I think as those principles were being developed in collaboration with our colleagues in ONC and CMS and others. I think several of us at NCQA, reflecting, we weren’t as overt about the principles, what we’re doing to work on the digital measures and all the things that we’ve been talking about. But, a lot of what we were doing was based upon those principles. So even though the principles may have come after the work, I think they were always guiding us, and now we’ve just surfaced them through some great conversations. And checking with others, as we’re trying to do through this webinar and other communication strategies with the external environment. So, it wasn’t just us developing those; it was in concert with others. And we hopefully we’ll publish and get some more feedback on the status.

Ben Hamlin: And when we were developing those principles, we were using those that we had originally outlined for ECDS. We tried to work them in it because it’s a forward-thinking strategy. We are really trying to harmonize these efforts and make sure that we are all on the same page in terms of what we’re proposing.

Michael Barr: And I think they’re very future-oriented, too. So, kind of what we’re doing now, but also projecting where we hope to go. Again, based upon feedback. We thought it was time to put something out that was a little clearer and more evident about what’s driving [development].

Andy Reynolds: Can you please elaborate on the quality data model? Where can we get to know more about the quality data model, or should we just study FHIR?

Ben Hamlin: The best resource for the quality data model is the eCQI Resource Center published by CMS. They have a comprehensive set of resources to look up quality data model. The quality data model is still in place, so I would get some familiarity with it. But I am personally more in favor of FHIR at this point in terms of its flexibility and its usability across more than just the quality domain. There’s a lot to learn there so if you only can pick one
or the other, you might want to think about FHIR. But again, our measures are currently using QDM CQL. So, in order to do HEDIS digitally, you need to understand QDM at least to a minimal extent.

Michael Barr: And the FHIR resources are on…?

Ben Hamlin: There’s also a lot of information on the eCQI resource center about FHIR, but the best resource for FHIR [is to] go to https://www.hl7.org/fhir/ and look up information on FHIR. There’s an entire series of web pages dedicated to just about every aspect of FHIR you could possibly ever want to know.

Ben Hamlin: There are a lot of resources available for FHIR. Some introductory, to very, very, very, very, very technical.

Andy Reynolds: A question after your own heart, Ben: What is NCQA’s plan for FHIR, or if you haven’t decided, when will you decide whether you will switch to FHIR?

Ben Hamlin: We are deciding right now. We are weighing every single possible variable. Because again, we don’t want to make any moves prematurely, but we’re also being very cautious as we’re deploying our digital measurements strategy. We are looking at FHIR. We are thinking about measures in FHIR. We are working with CMS about their schedule for converting to FHIR because we want to remain aligned with CMS. But again, I personally and professionally see a lot of utility in FHIR that goes well beyond quality measurement. Other organizations such as NIH is and CDC are looking at FHIR. So, it’s not just about quality measures anymore, in terms of the standards we’re using. It offers great opportunity for us.

Michael Barr: The only thing [is] that it’s not a matter of when and how fast. And so stay tuned.

Andy Reynolds: Do ECDS requirements need any major overhaul for current EHR applications?

Ben Hamlin: Well, without knowing much about your current EHR applications, I would say it is likely, but it’s not necessarily required. To extract, transform and load data to a place where you would be then running measures against it is really going to be defined by which components you bought for your system, but also the ability of your vendor to be certified by NCQA to do e-measure reporting. So again, HEDIS ECDS measures use the same language as the CMS MIPS measures, and that’s intentional. The vendors that can support MIPS should theoretically be able to support ECDS because they’re speaking the same language. And we’re hoping that future standardization of more HEDIS measures will allow more data to be extracted from EHRs more easily.
Ben Hamlin: We are working with HL7 through the DaVinci Project to understand how data exchange could happen between payers and providers, and providers and providers, and providers and payers using EHR-level data. It’s an ongoing process, but again, the idea of using these national standards or international standards for measure specifications we hope will facilitate that work and our ability to produce this information in a consistent way.

Andy Reynolds: Okay. Looks like we have almost 500 people still on the line. So, let’s keep going. How can ECDS measures be used at the physician level rather than just the health plan level?

Ben Hamlin: Well, this is interesting. You wouldn’t want to take the HEDIS ECDS specification in its entirety and use it at the provider level. However, the way to measure is specified: It’s looking for individual data around a person. Right? So, the depression screening measure looks for an individual screening of a depression screening tool being applied. And a score for that tool for each individual person.

Ben Hamlin: The core clinical logic of who should be screened and when they should be screened is consistent for the provider level to the payer level, right? If you have a member, you have a patient. Persons should be screened once a year for depression. That’s what the clinical guidelines say. The attribution of who has done the screening and who has been screened, and then information can be both in front of that core critical logic. And that’s where the program differentiation comes. So, for MIPS, you would report a different attribution logic on the front end of that.

Michael Barr: So, in other words, the people that a clinician saw as [crosstalk] member that was enrolled in the health plan for a particular period of time.

Ben Hamlin: But the fact of who had the screening and how they can transmit that information from the provider to the payer. A PHQ-9 being administered or what the score was for any one individual; that information can go back and forth between the payer and the providers. So that the provider does not have to screen everybody they see. Because they may know already that they’ve been screened by somebody else or the payer is already doing that screening for them. Right?

Ben Hamlin: So, who should be screening and how the information about who has been screened can be transmitted back and forth very easily. Because the measure is looking at a very individual level. It’s not excluding people for enrollment criteria anymore. It’s not excluding people for variables that just aren’t in claims. So therefore, the provider doesn’t really have that claims mindset, but the clinical mindset, right? And we try and align all the different variables in the measures.

Andy Reynolds: Are the measure year of 2020 and measure year of 2021 specifications going to be similar? I think this question refers to—
Michael Barr: The timeline. So, in July 2020, we’re releasing the measurement specs that apply to 2020 and 2021. And so, the measures will be the same. Obviously, there always are annual updates in terms of the technical side, but you can see that the measures released in a circle are Volume 2 measurement years 2020 and 21.

Andy Reynolds: Is NCQA working with a large EMR to build LOINC codes into extractable data for all? This seems like a huge IT lift.

Ben Hamlin: Well, we’re working with large vendors to understand the presence of standardized codes like LOINC in their systems. What are they collecting? But that is also part of our measure development process. When we have a need for a new code to define, for example, for our Unhealthy Alcoholic screening, a specific standardized question that you would want to have a standardized terminology for. We’re working with Regenstrief to propose those codes and going through that approval process to get new codes developed and approved so that we can use them in our measure. Not only can we use them in our measure but since it’s the standardized terminology, everyone can use the code for all their other programs.

Ben Hamlin: Essentially, we’re doing some of the work for you in terms of requesting the codes that are needed from bodies who maintain these code systems and then publishing [them] in our measures so that they can be then used on the data collection end. So, we’re not going to propose a code that no one has and no one is ever going to have. But we are trying to reference more standardized, more person-centric terminologies that are used for specific purposes. Like as intended for use as observational data, observational clinical data, clinical observations.

Ben Hamlin: ICD and CPT were intended for assessing procedures and claims. I used a CPT code to define a clinical observation [but] it’s not really its intended purpose, so we’re trying to move away from that. They’re still going to be in many of our measures, because people are using them. So we don’t want to just cut that leg off to save our measure protocol. But we’re really trying to move towards the more consistent, more intended use for these terminologies in our measures.

Andy Reynolds: We still have a few questions and more than 400 people on the line, so let’s keep going. What is the difference in terms of topic or audience between the Digital Quality Summit on one hand and the Health Care Quality Congress (HQC) where the PCMH Congress on the other? What kind of person should attend both or that kind of event?

Michael Barr: The PCMH Congress is really oriented around the Recognition programs—you would say about primary care specialists, the neighborhood, if you will, the medical home neighborhood. Some of those who’d be very interested in the digital information in terms of measures and so on. I think some of the topics might reflect that. But the emphasis
Michael Barr: And we have done some presentations there on this topic that have been well attended and well received. I think the Digital Quality Summit is a different kind of meeting where we have stakeholders from across the range, as you saw in this bar graph. And that diversification is continuing. And it’s more of a hands-on roll up your sleeves, get in some traction and work on specific things and produce things collaboratively than the other meetings. Certainly, their engagement and conversations in the hallway at the PCMH Congress and HQC. But those are more structured and people are working more closely together on a topic in breakout rooms and the Digital Quality Summit. So, I think they are complementary; maybe some overlap in terms of interested personnel. But [it] really speaks to different types of activities.

Ben Hamlin: It somehow acts as bridging that gap too. One of the things we’re thinking about for this next summit is a theme or a track on provider engagement around data exchange, which would then involve the payers and the providers, or ECD measures of providers, from these two different entities to understand how they would facilitate this, moving forward. So again, the summit is a very different meeting. It’s not your traditional scientific summit or scientific meeting. We’re really trying to sort of break down the barriers and bridge the gaps between these different entities who are doing things from different ends of the spectrum. And so really everyone’s welcome. And I highly encourage you to come; it’s been a fantastic event for the last couple of years and I’m looking forward to another one.

Andy Reynolds: Well, it’s like we’re coming up on a quarter after the hour, so why don’t we take one more question. Does NCQA have plans to certify individual consultants to better assist explaining to providers how digital measures and Allowable Adjustments work?

Michael Barr: That’s an interesting idea. And to our knowledge, there are no current plans. But it’s our personal answer. Email us and let us know what he or she is thinking. We’d be happy to hear their thoughts.

Ben Hamlin: When we do certify HEDIS or others who are supposed to be informed about all these different events, I guess in many ways they’re kind of our current consultants who are certified.

Michael Barr: And I should have said that, so thank you.
Michael Barr: All right; well, thank you very much, everybody. We really appreciate you sticking with us and through persevering through the technical difficulties earlier. Thanks to David at WebEx for helping us do this and thanks to the whole team—Emily, Ben, Andy—for making this work. Look for the future dates for webinars. And make sure you register for the Digital Quality Summit when we post that. And look for the Digital Measurement Community launch. We anticipate that in March and you can sign up to get notified on the website. Thanks, everybody. Have a great holiday season and New Year.