

# The Future of HEDIS: Episode 4—December 10, 2019



## The Future of HEDIS®

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Episode 4: December 10, 2019

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- 2 Michael Barr: Hi; I'm Michael Barr, Executive Vice President for Quality Measurement  
4 and Research at NCQA. Joining me today are Emily Morden, NCQA's  
6 Director of Electronic Measurement Strategy, and Ben Hamlin, NCQA's  
8 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.




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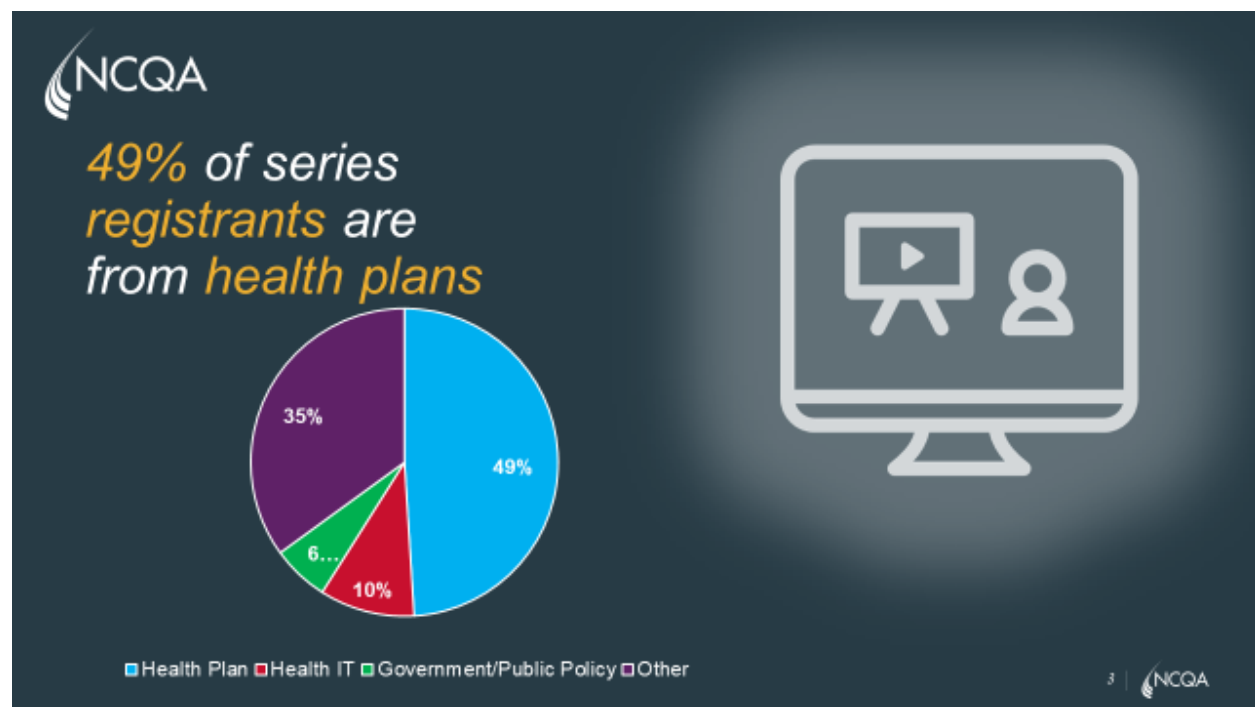
Welcome!

*Episode 4 of  
this webinar series*

*6,622 registrants  
in this series*



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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



16 dates and update for the Digital Quality Summit for 2020. Roughly half of  
18 the people—49%—who have taken part in this series work for health  
20 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.



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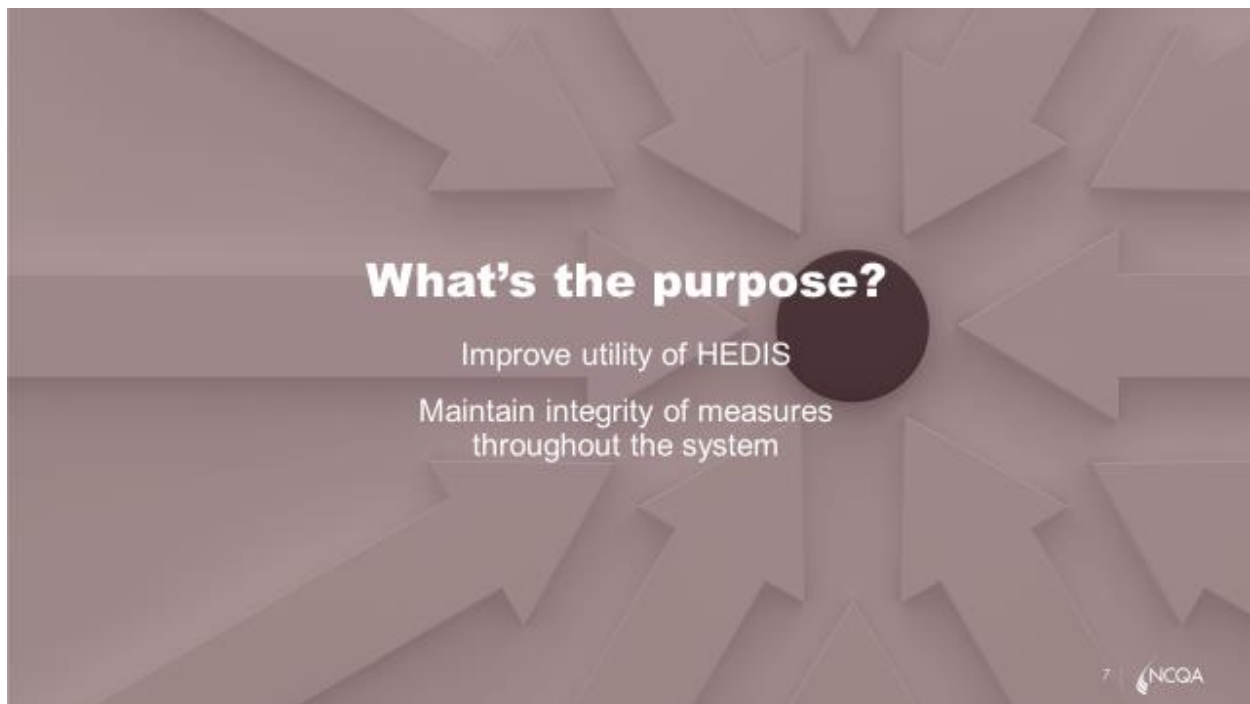
- 24 Michael Barr: We especially want to welcome the many people on today's call who are  
 26 new to this series. About 43% of you are learning about these topics for  
 28 the first time today, and we've been really encouraged about how many  
 30 people have joined these series in episodes 2, 3 and 4—that is, after the  
 32 series started. It's also good to see the number of people interested in  
 34 these topics growing. Because we understand so many of you are seeing  
 36 this information for the first time, we'll start with a thorough summary of  
 38 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.





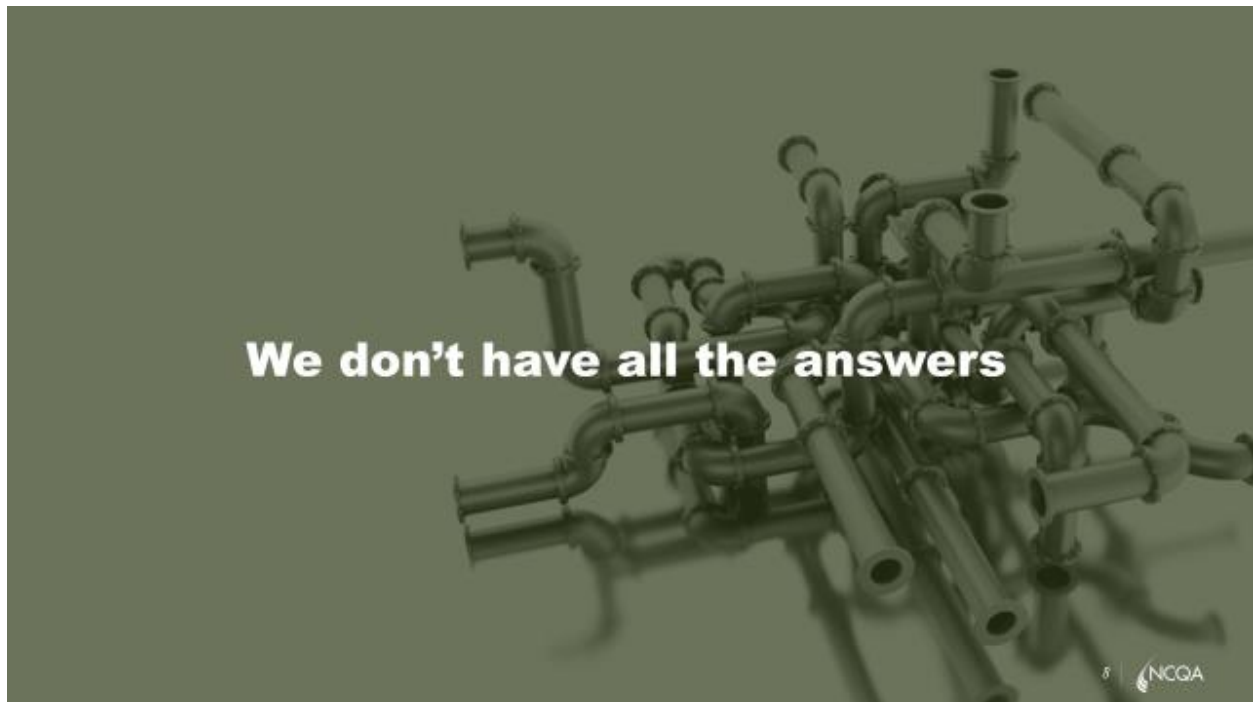
- 40 Michael Barr: So, why are we here? Why are we talking about HEDIS, the future of  
42 HEDIS? Obviously, you know we've been around for quite a long time. I  
44 think you also know (Emily would acknowledge it) things are changing.  
46 They're changing quickly. The environment around us about health care  
48 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.





- 50 Michael Barr: What we want to do in terms of our strategy is improve the utility of  
52 HEDIS. We've done great over 30 years. We need to be around—and we  
54 want to be around—for a lot longer. And so, to involve the portfolio of  
56 measures and be responsive to the needs of the health care community  
58 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.



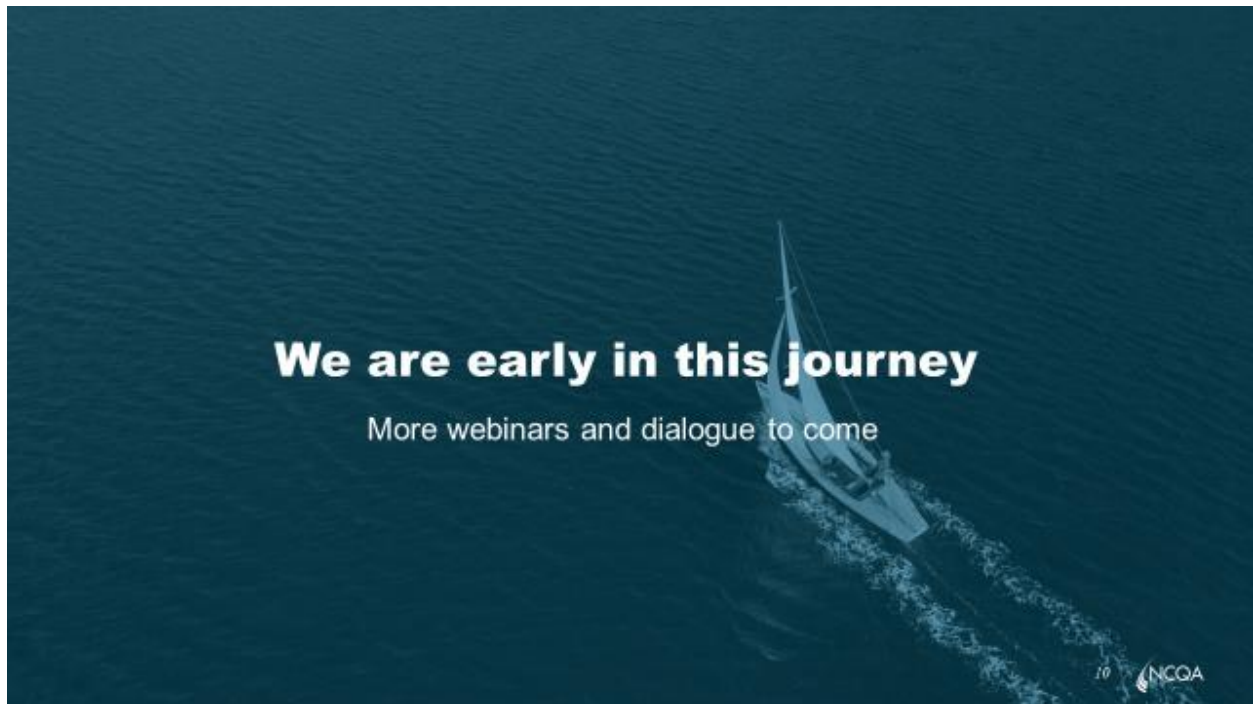


- 60 Michael Barr: We don't have all the answers and we are going to institute any changes  
62 we talk about gradually. It's a process, not an event; collaboration, not  
commands. We also know that the ratings across the health system for  
the types of change we're talking about varies in sort of a piecemeal way.

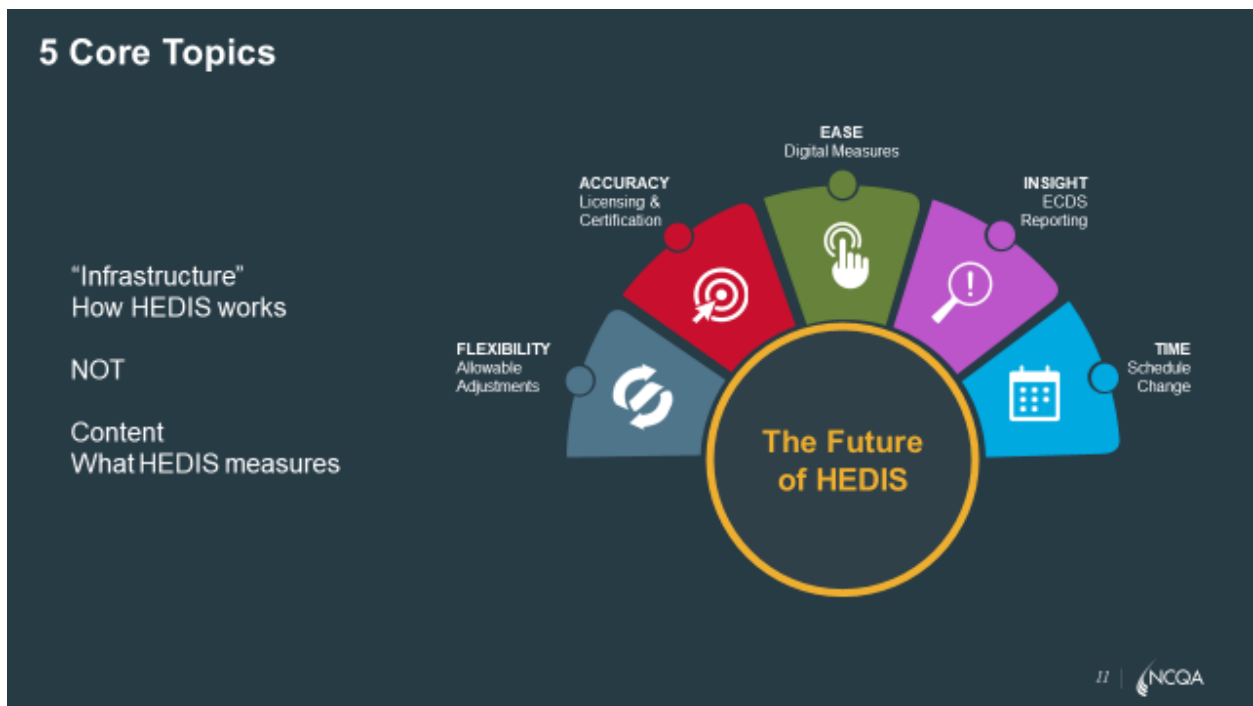


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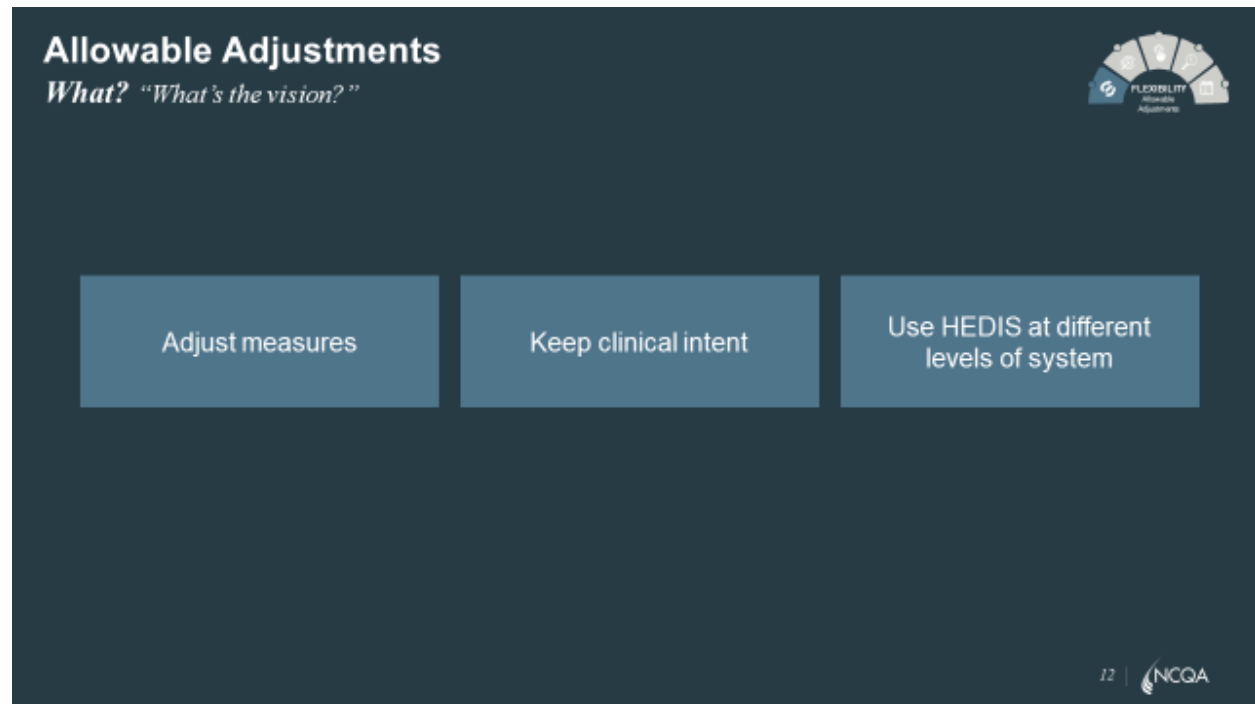
- 66 Michael Barr: Here we've got changes; they're going to be gradual. And it's very  
68 important you know that we're evolving in this journey. You've seen and  
heard some of the old webinars so far. And we welcome your feedback  
today in the future.



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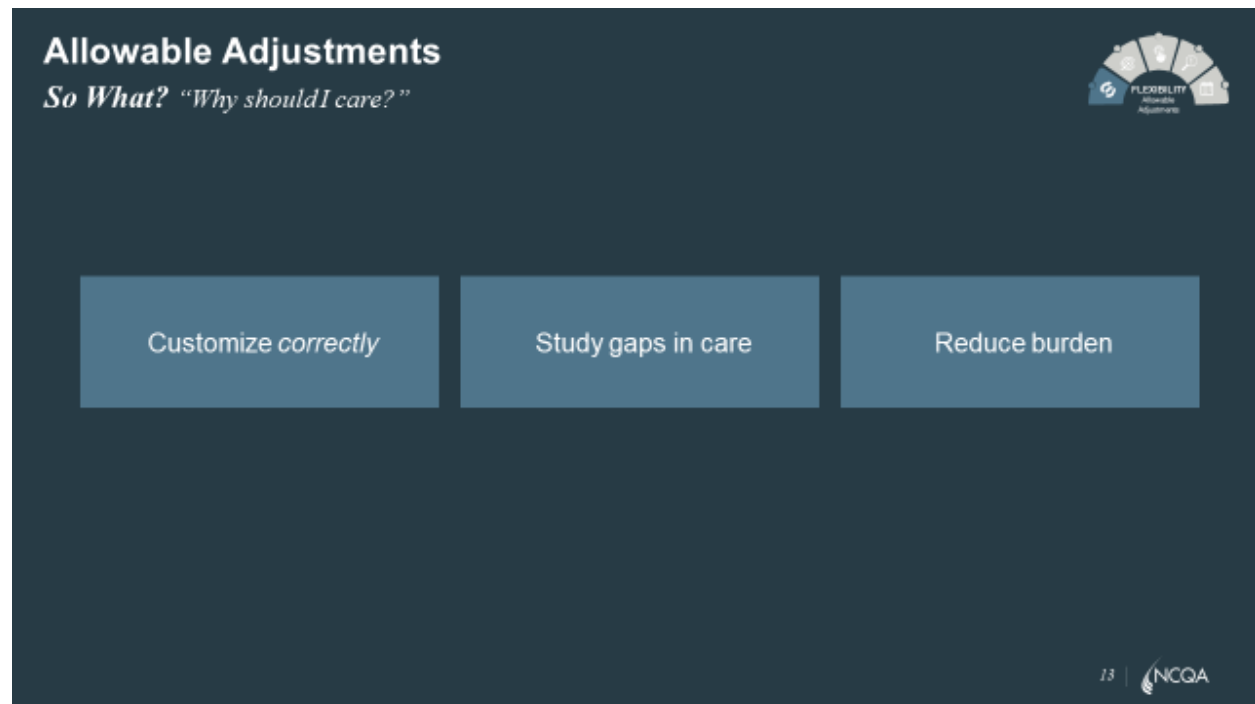
Michael Barr: There are five main topics I'm going to cover today. It's all about what you might call "the HEDIS infrastructure" or how HEDIS works; not about the content of the measures or what HEDIS evaluates. The five topics—add another one—Flexibility in Allowable Adjustments; Accuracy in Licensing and Certification; Digital Measures; Electronic Clinical Data Systems reporting; and our Schedule Change.



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.

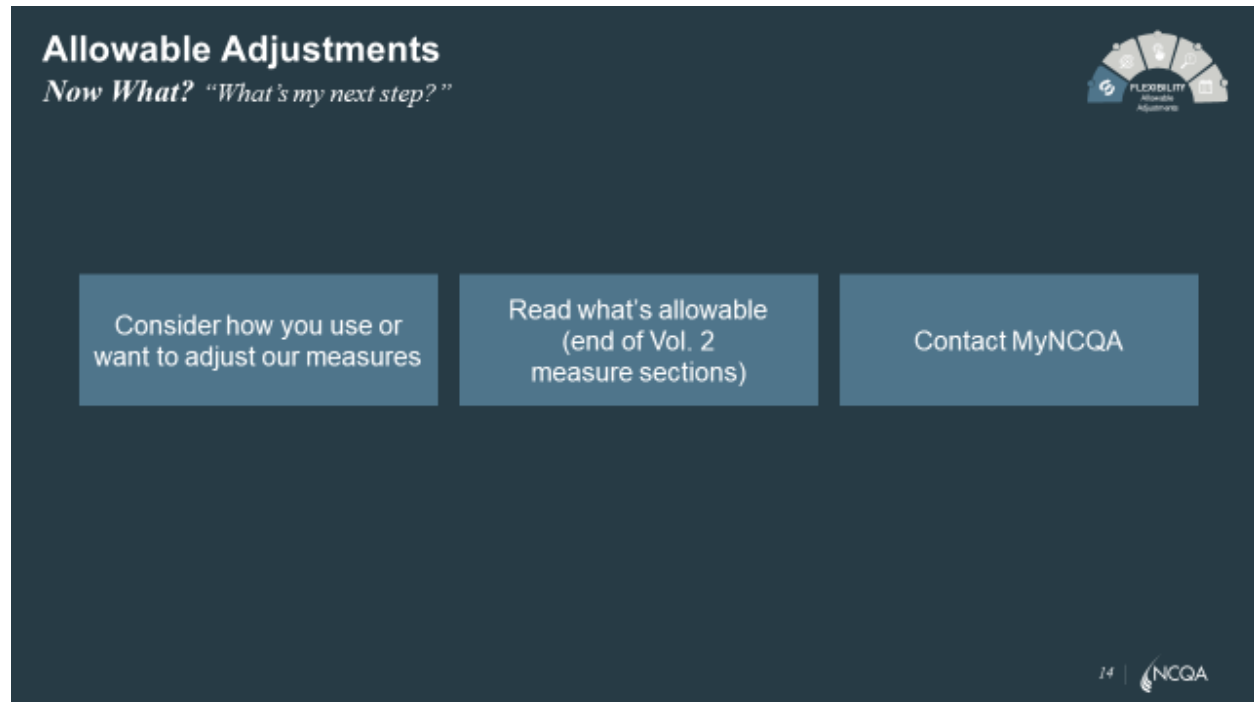
Michael Barr: Allowable adjustments are also how you can now use HEDIS at different levels of the health care system and for purposes other than health plan reporting. For example, you can filter results by product lines, turn off enrollment criteria, but focus on a population subset. For example, a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





- 92 Michael Barr: Why should you care? What's the SOA? Allowable adjustments help you  
94 use measures correctly while adhering to the underlying clinical guidance  
96 or evidence base. They allow you to have the freedom to use HEDIS  
98 measures prospectively within delivery systems to guide clinical  
100 interventions and close gaps in care. We also think this will help reduce  
102 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.





### Allowable Adjustments

*Now What? "What's my next step?"*

- Consider how you use or want to adjust our measures
- Read what's allowable (end of Vol. 2 measure sections)
- Contact MyNCQA

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- 104 Michael Barr: What's the next step? Think about how your users might want to adjust
- 106 them for other uses. We encourage you to read details about Allowable
- 108 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.



## Licensing & Certification

*What? "What's the vision?"*



All HEDIS users need  
a license agreement


Commercial services based on  
HEDIS also need certification

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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.



**Licensing & Certification**  
*So What? "Why should I care?"*



Accuracy, reliability

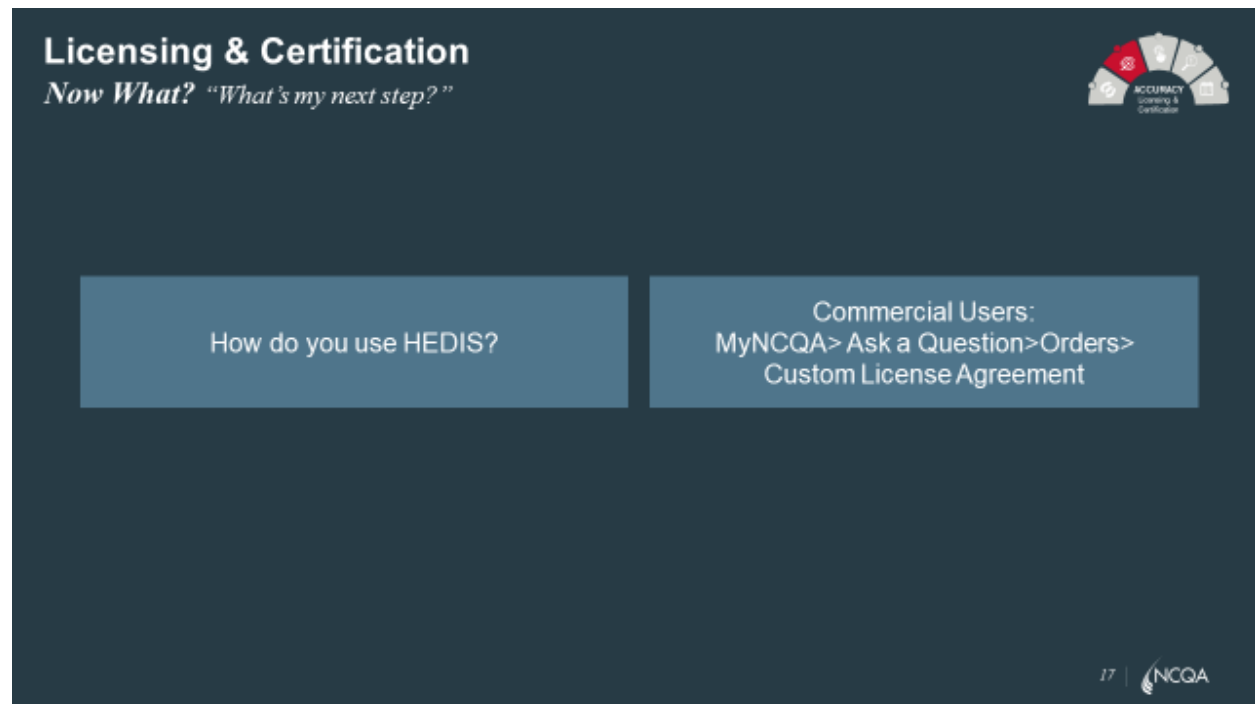
Trust in value-based payments

Apples-to-apples comparability

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- 122 Michael Barr: If you are a health plan that uses internal software to report HEDIS, your  
124 software must be certified starting in 2021 for HEDIS results reported in  
126 2022. Any software you use to calculate or report HEDIS measures or  
128 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.





- 130 Michael Barr: The point of Licensing and Certification is helping ensure these results  
132 are accurate, reliable and can be used for all the purposes you intend;  
134 most importantly, improving clinical care. Our priority is confirming that  
136 measured calculations are based on accurate measure specifications.  
138 Measure accuracy should be a priority, because value-based payment  
140 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.
- 142 Michael Barr: Consider how you use HEDIS. If you use HEDIS for internal quality  
144 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  
146 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.



## Digital Measures

*What? "What's the vision?"*



Digitalized versions of  
existing measures that use  
traditional reporting

Measures written as  
computer code  
(machine-readable)

Download measures directly

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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.



**Digital Measures**  
*So What? "Why should I care?"*

- Easier transfer of measures into your IT system
- Reduce interpretation, recoding, human error
- Standardize to ease use across care continuum

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- 160 Michael Barr: Digitalization means that NCQA writes measures as computer code so  
162 you don't have to. It eases the need for you to read, interpret and read  
164 code measures and that will hopefully avoid human error and non-  
166 standardization. Our digital measures follow industry standards so HEDIS  
168 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.
- 170 Michael Barr: We are exploring additional industry standards such as FHIR, Fast  
172 Healthcare Interoperability Resources to ensure measures remain aligned  
174 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.
- 176 Michael Barr: Right now, NCQA is the most watched video 2019 on YouTube, our  
178 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.)





- 180 Michael Barr: I understand some of you may have had some difficulty listening to the  
182 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](https://ncqa.org/digital-hedis-video).
- 184 Michael Barr: Now I'm going to try something new, also. We're going to ask you to  
186 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  
188 respond and I will share the results. The questions are, what is your  
190 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  
192 used it and [am] fairly comfortable." D is "have done a few  
implementations, taught others, worked on implementation guidelines."  
194 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  
196 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.



## ECDS Reporting

*What? "What's the vision?"*



A type of digital measure

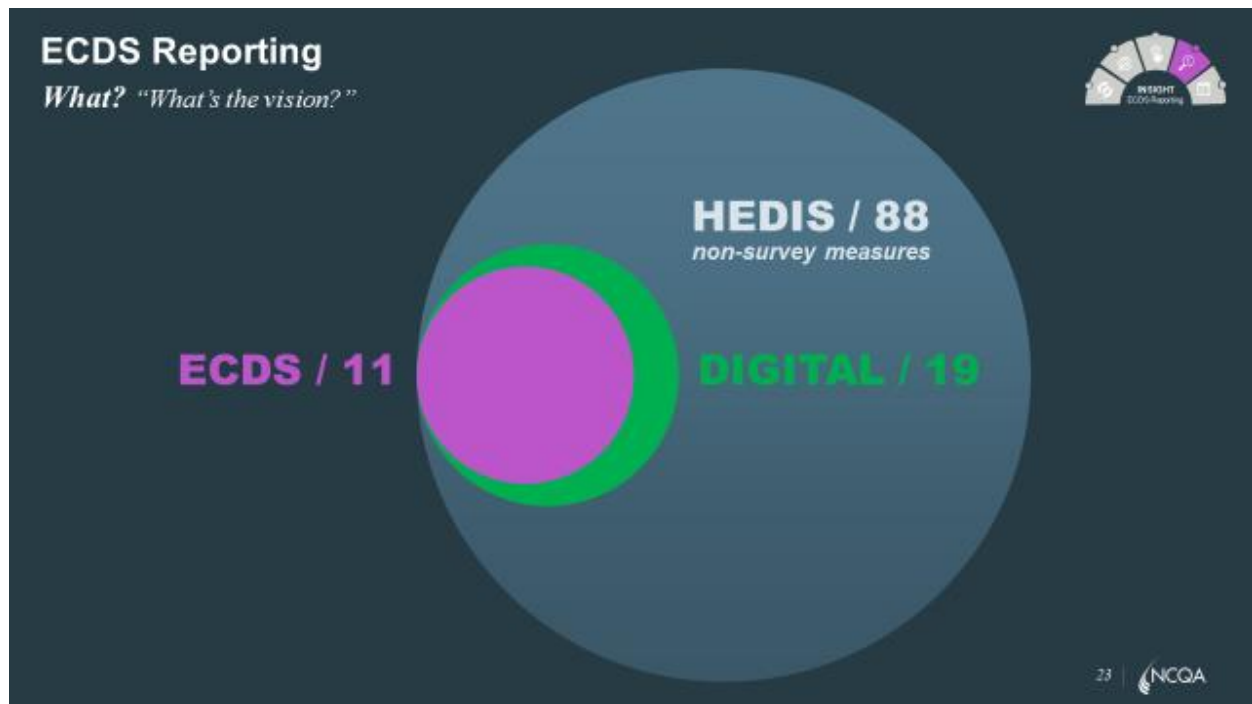
Report clinical data according  
to data source

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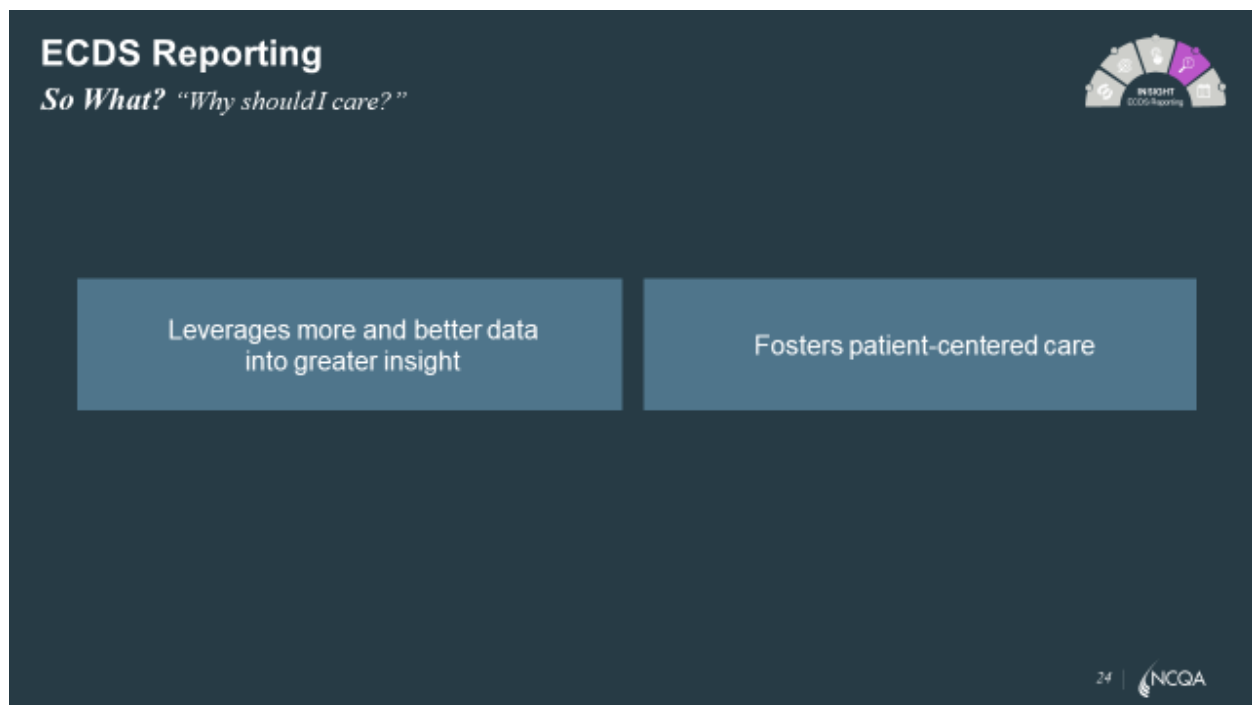
Michael Barr:

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.





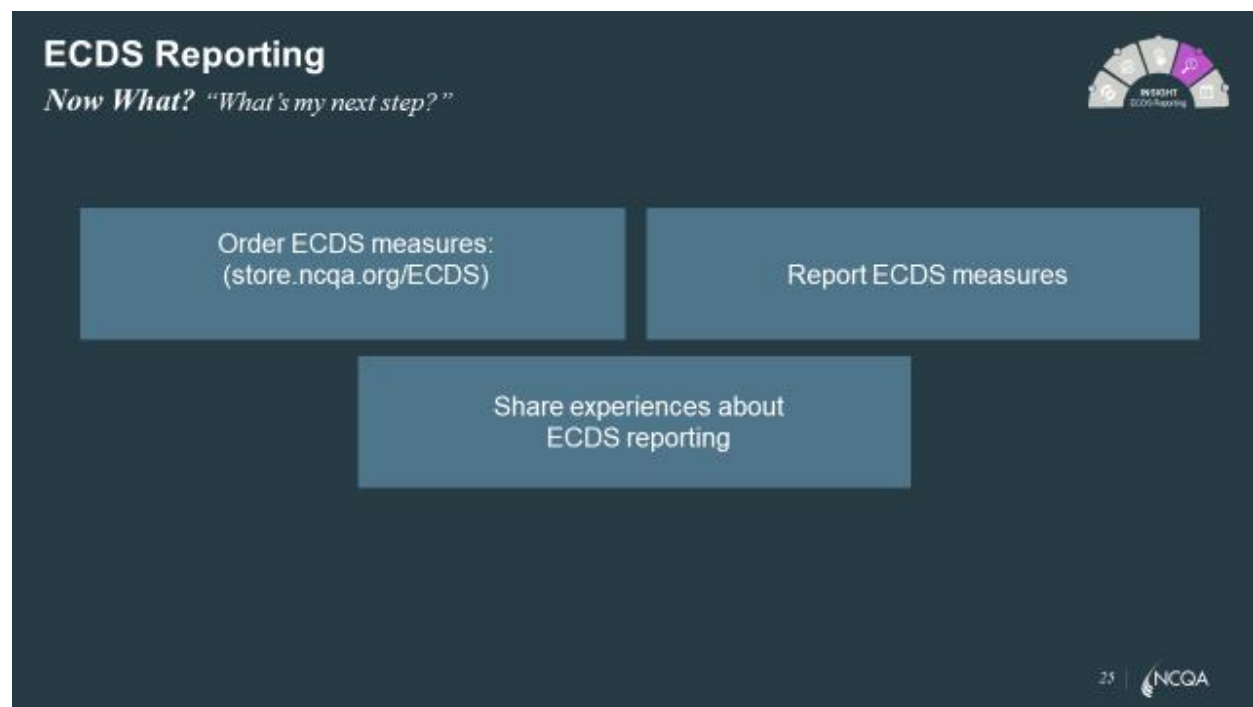
- 210 Michael Barr: This chart shows the relationship between ECDS measures and regular
- 212 Digital Measures and traditional measures for which we've added digital
- 214 specifications. The important part is that these are all HEDIS measures.  
And the main takeaway is secondarily that ECDS measures all digital, but  
now all digital measures are ECDS.





216 Michael Barr: ECDS brings all the efficiencies of the digital measures I mentioned a few  
 218 minutes ago and quality measurement towards greater use of electronic  
 220 clinical data. ECDS measures encourage use of clinical information from  
 222 many sources, not just from EHRs. But because we anticipate more  
 224 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  
 226 specifies an age range as inclusions. It does not account for risk profiles  
 228 or tissue preferences very well. Any ECDS measure could include all the  
 230 logic associated with clinical guidelines. You can ensure, with one  
 232 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.



234 Michael Barr: Now, we know several health plans already have connections to  
 236 electronic health records, use data aggregator, the Health Information  
 238 Exchanges, immunization registries and case management systems to  
 240 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 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**)

**GO  
ECDS**

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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.





- 260 Michael Barr: This next slide shows an artist's rendition of our new online report cards,
- 262 which will highlight plans that report ECDS measures. This report card
- 264 launches in September of 2020. We're adding this feature to our display
- 266 because we want to acknowledge health plans that are taking the
- 268 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.



## Schedule Change

*What? "What's the vision?"*



Current: 6-month lag  
(Jan-Dec measures = July notice)

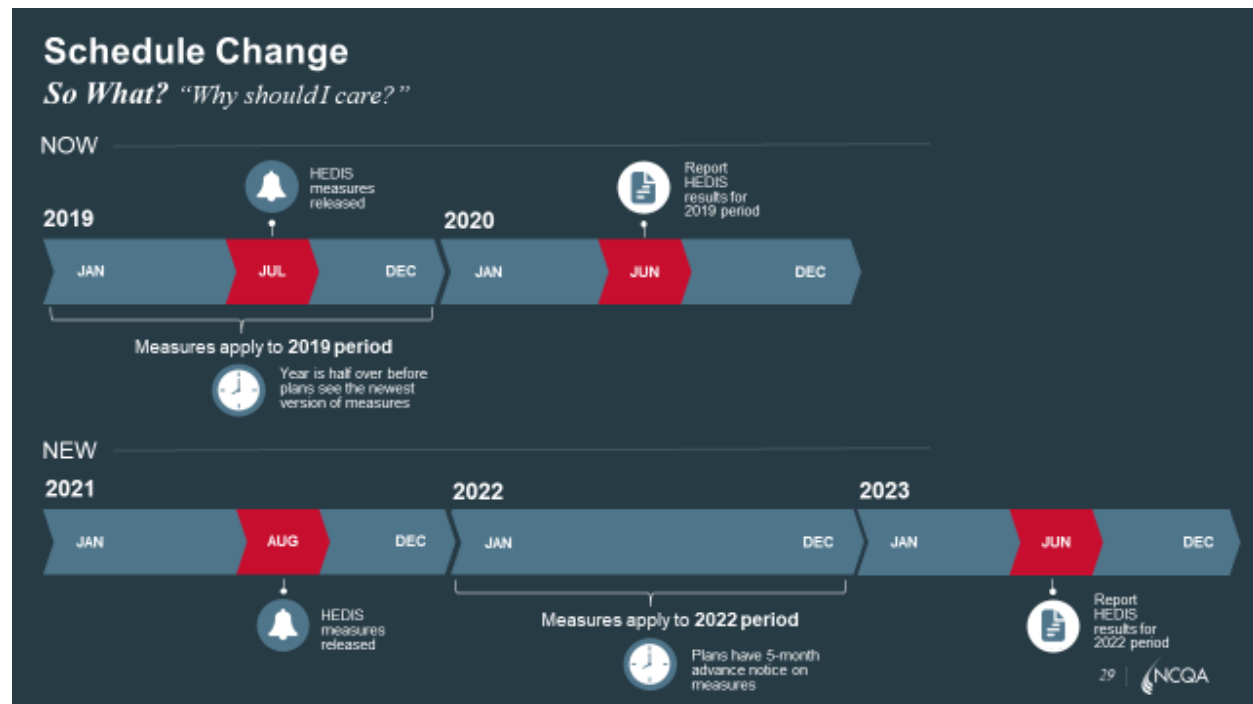
Future: 5-month head start  
(Jan-Dec measures = *prior* Aug notice)

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Michael Barr:

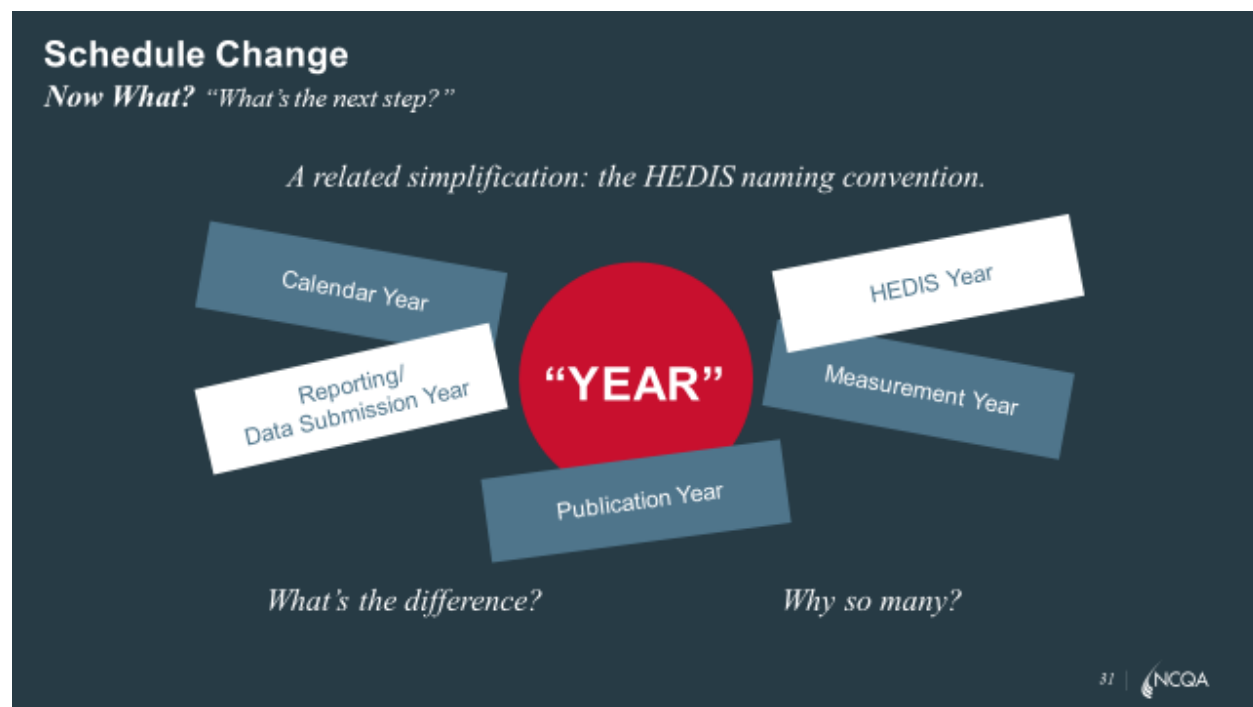
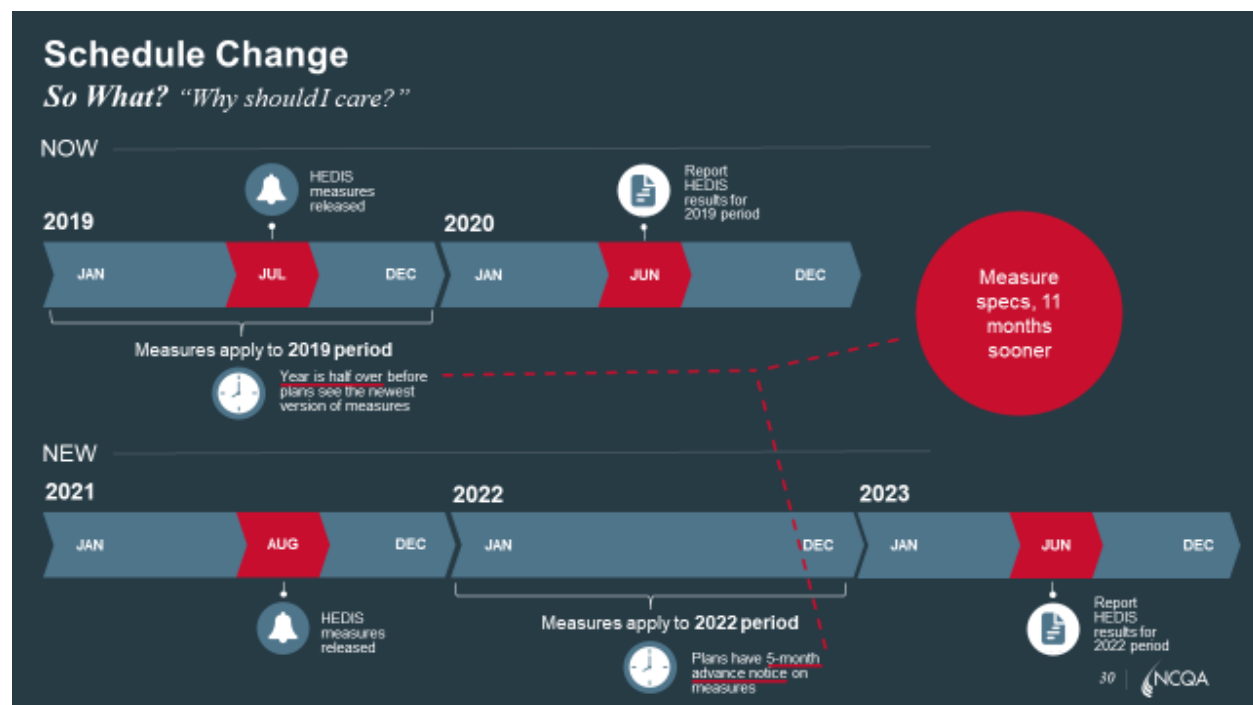
Now for the last topic; a change that I'm going to cover: A change of the HEDIS schedule. What's the big idea? We're changing when we specify the measures that apply to a measurement here. Let me show you what I mean. Our traditional schedule is to release the measure specs in HEDIS Volume 2 halfway 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.*

	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022
Publish Vols. 1 & 2	7/1/2020	7/1/2020	8/1/2021
Publish Vol. 2 Technical Update	10/1/2020	3/31/2021	3/31/2022
First Year Public Reporting	10/1/2020	10/1/2021	10/1/2022
Complete HEDIS Vendor Certification (Survey)	12/15/2020	12/15/2021	12/15/2022
Complete HEDIS Vendor Certification	2/15/2021	10/1/2021	7/1/2022
Data Submission Due	6/15/2021	6/15/2022	6/15/2023

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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.



Before we continue...

*Let us hear from you again*

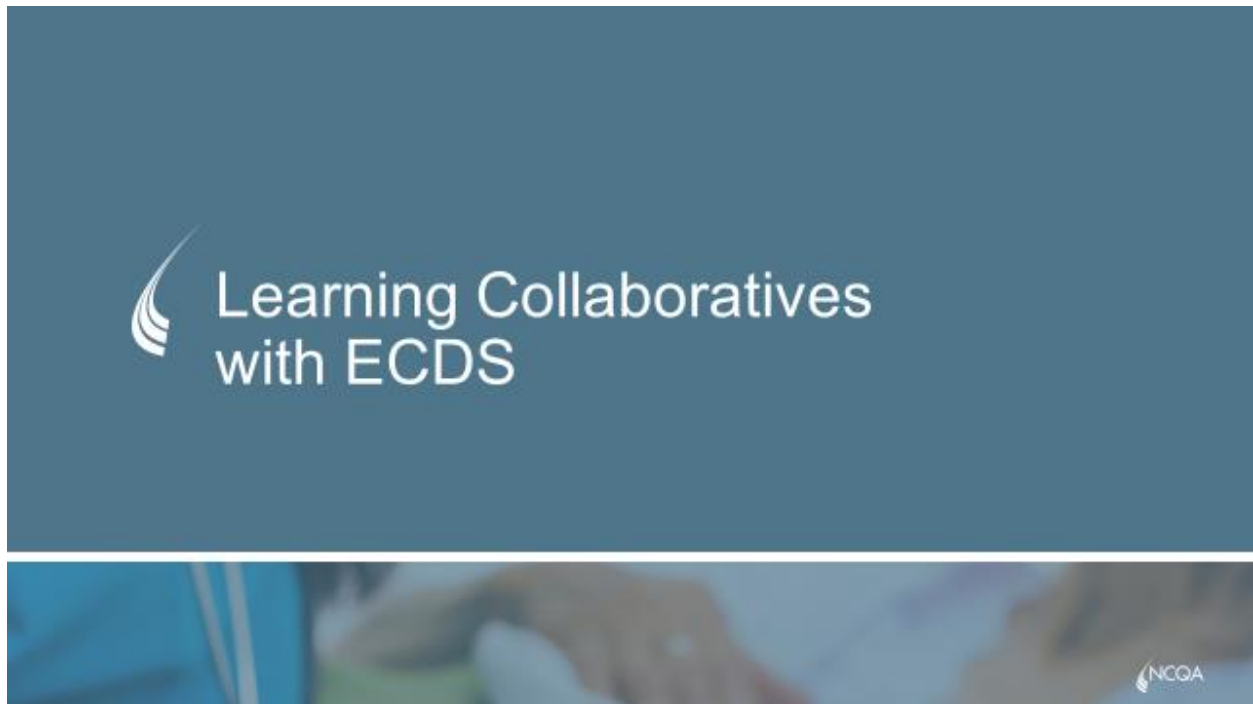


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Michael Barr: We're really interested to hear from you because this will help guide what we do next in terms of setting up the webinars for next year. Some of the high-interest topics we've heard before were Digital Measures, ECDS, and Schedule Changes. 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.





326 Emily Morden: Thank you, Michael. My name is Emily Morden. I'm pleased to share with  
328 you all today some findings from our learning collaboratives with ECDS  
330 measures. As we just discussed, we know that ECDS measures and  
332 reporting these measures is a new endeavor for many folks. And we also  
334 know that our behavioral health ECDS measures are important and can  
336 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.



## Implementation of Measures and Quality Improvement



### **Alcohol Learning Collaborative** (2017-2020)

Funded by the Centers for Disease Control and Prevention & Substance Abuse and Mental Health Services Administration

*Participants:* EmblemHealth (NY), GOBHI (OR), S. CA Kaiser Permanente (CA)

### **NCINQ Adolescent Depression Collaborative** (2018-2020)

Funded by the Agency for Healthcare Research and Quality & CMS

*Participants:* Affinity (NY), Excellus BCBS (NY), GOBHI (OR), CenCal (CA), AmeriHealth Caritas (DC)

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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.





360 Emily Morden: So, what have we learned so far in terms of the facilitators and the  
 362 barriers to collecting these measures and making improvements on  
 364 them? Well, in terms of the facilitators at the top here, we have found that  
 366 getting stakeholders engaged is really a key piece. And this includes  
 368 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.

370 Emily Morden: Secondly, having a project champion is helpful to continue doing this hard  
 372 work and keep things moving forward. And, to get leadership support and  
 374 the needed resources for the project. And lastly, thinking how we can  
 376 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.

378 Emily Morden: And so, there's a lot of work still to be done in being able to get that  
 380 clinical data flowing for these measures. Now we're also seeing that in  
 382 many places, there's still lack of integration; particularly with behavioral  
 384 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





386

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

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388 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.

398 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.



## Accessing Clinical Data for HEDIS Reporting

*Learning from the experiences of AmeriHealth Caritas District of Columbia*

- Began effort ~5 years ago with collection of supplemental data from EHRs of two large Federally Qualified Health Centers
- With focus on depression ECDS measures also explored getting clinical data from internal case management programs and health information exchanges
- Findings:
  - Focus on practices/exchanges where the bulk of plan membership is represented
  - Incorporate data exchange with practices into value-based payment arrangements
  - Transform manual data collection processes into automatic feeds
  - Provide relevant data back to clinicians (e.g., provider portal)

*Listen to full podcast available here:*

<https://blog.ncqa.org/inside-health-care-020-pete-stoessel-amerihealth-caritas/>

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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

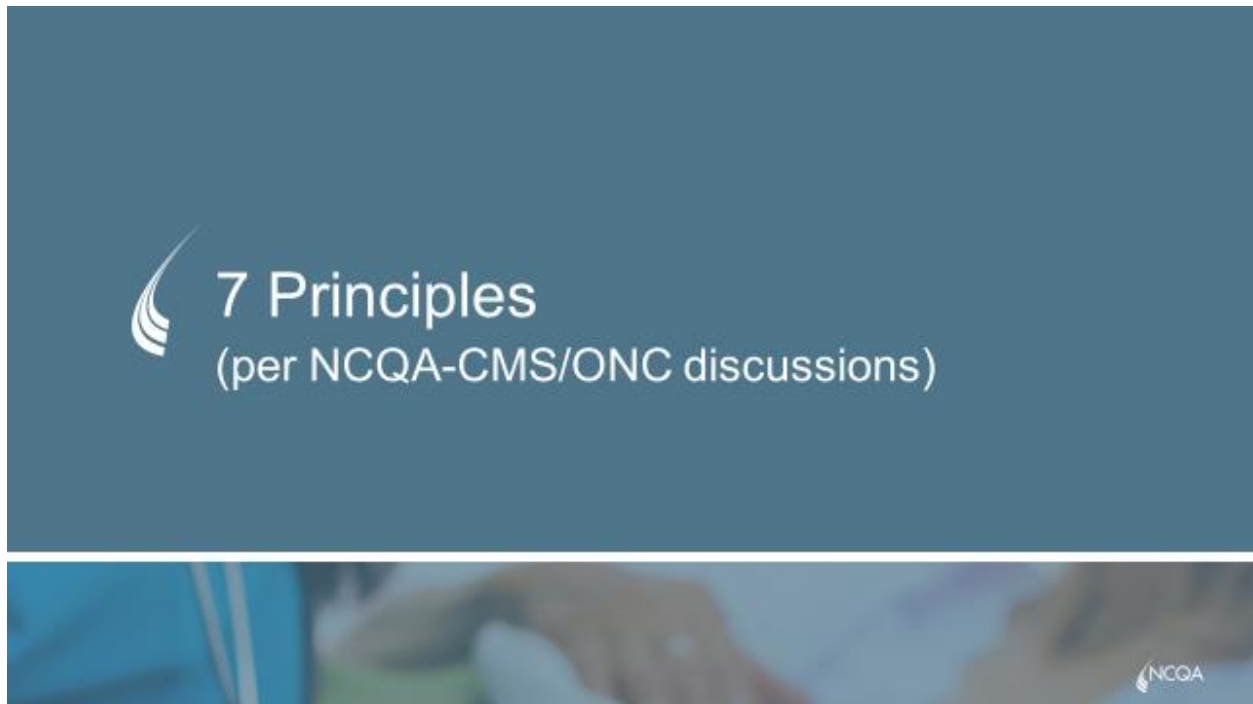
- Develop guide for reporting ECDS measures:
  - Addressing barriers/challenges
  - Using data collection tools
  - Balancing & interim measures to track performance
- Identify best practices and resources for improving care
- Case studies describing successful changes

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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.

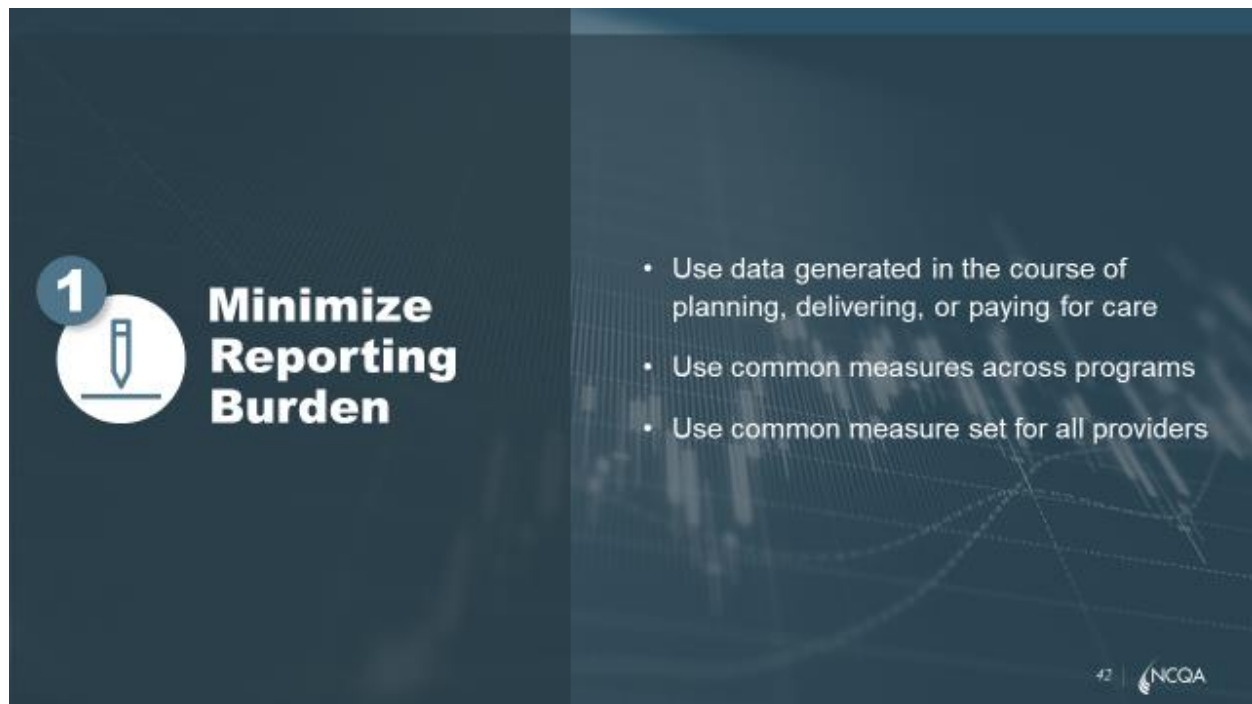
Emily Morden: I just wanted to share with you some of these early findings; stay tuned for more news in the future on other resources and findings that we must share coming out of these efforts. I think I'll turn it to Ben Hamlin now.





454 Ben Hamlin: Thank you, Emily. I'm going to go very quickly through what's next. We  
456 had a lot of successes with our early implementation of ECDS and we've  
458 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.

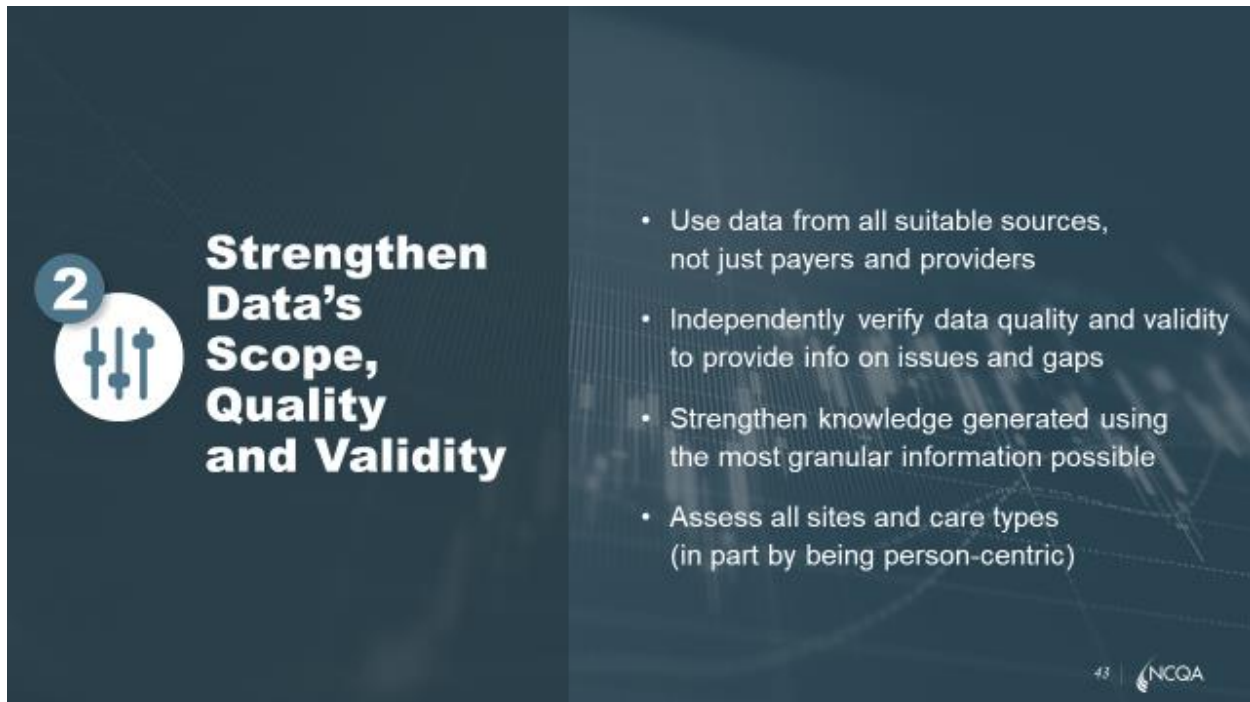




Ben Hamlin: First we've always been trying to understand how to reduce the burden of measurement and how we should really think about this. And some of the ideas we've come up with for the roadmap include using data that's generated during care and not continuing to impose additional requirements on 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.





**2 Strengthen Data's Scope, Quality and Validity**

- Use data from all suitable sources, not just payers and providers
- Independently verify data quality and validity to provide info on issues and gaps
- Strengthen knowledge generated using the most granular information possible
- Assess all sites and care types (in part by being person-centric)

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476 Ben Hamlin: Most importantly, as we're expanding the data that we intend to access to  
478 do these quality assessments, we really must ensure that the validity and  
480 quality of this data is maintained and improved upon. Of the process is  
482 particularly important as we start to obtain more granular information on  
484 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.

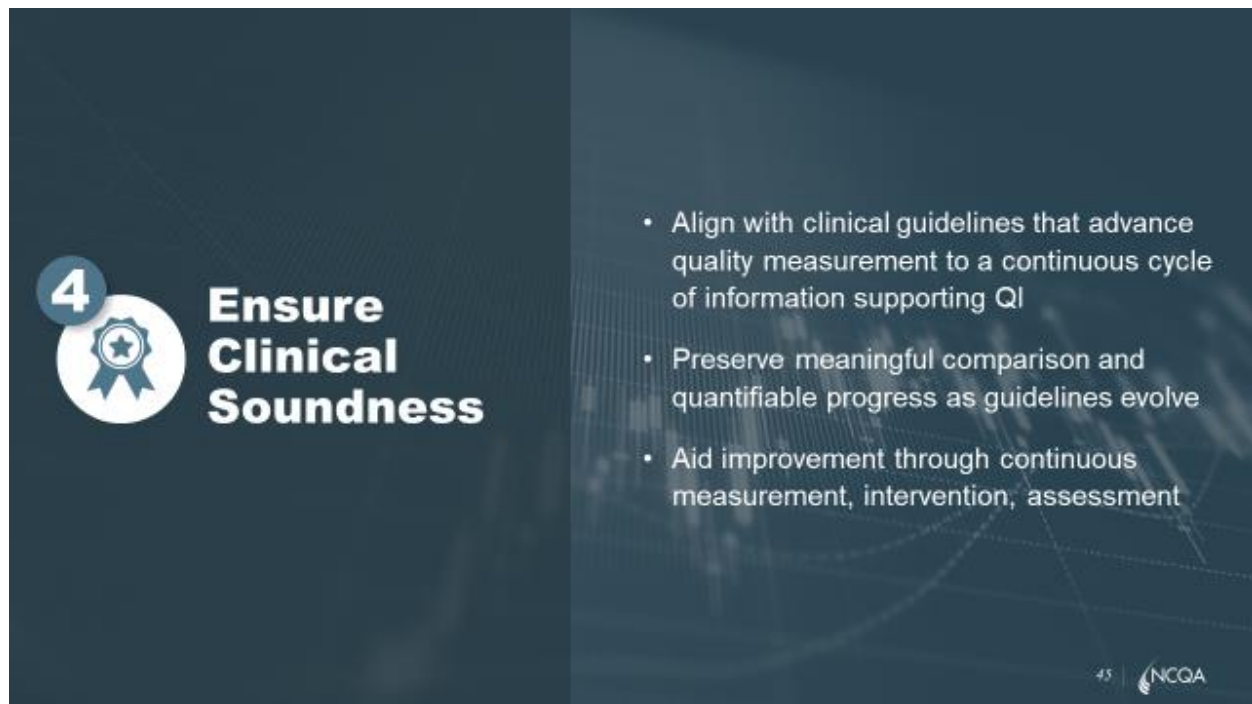




Ben Hamlin:

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.





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Ben Hamlin:

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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.





508 Ben Hamlin: As part of that process we're making sure that we're not inadvertently  
510 creating disadvantaged populations or providers by deploying new  
512 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.





**6 Align with Societal Goals**

- Select measures for impact on cost, quality, social determinants, equity and wellbeing
- Prioritize measures by anticipated benefit (value = resources used/projected benefit)
- Incentivize care for complex patients based on shared savings and improving health, not on benchmarks that complex patients cannot reach
- Separate patient characteristics from provider performance to avoid cherry-picking

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Ben Hamlin:

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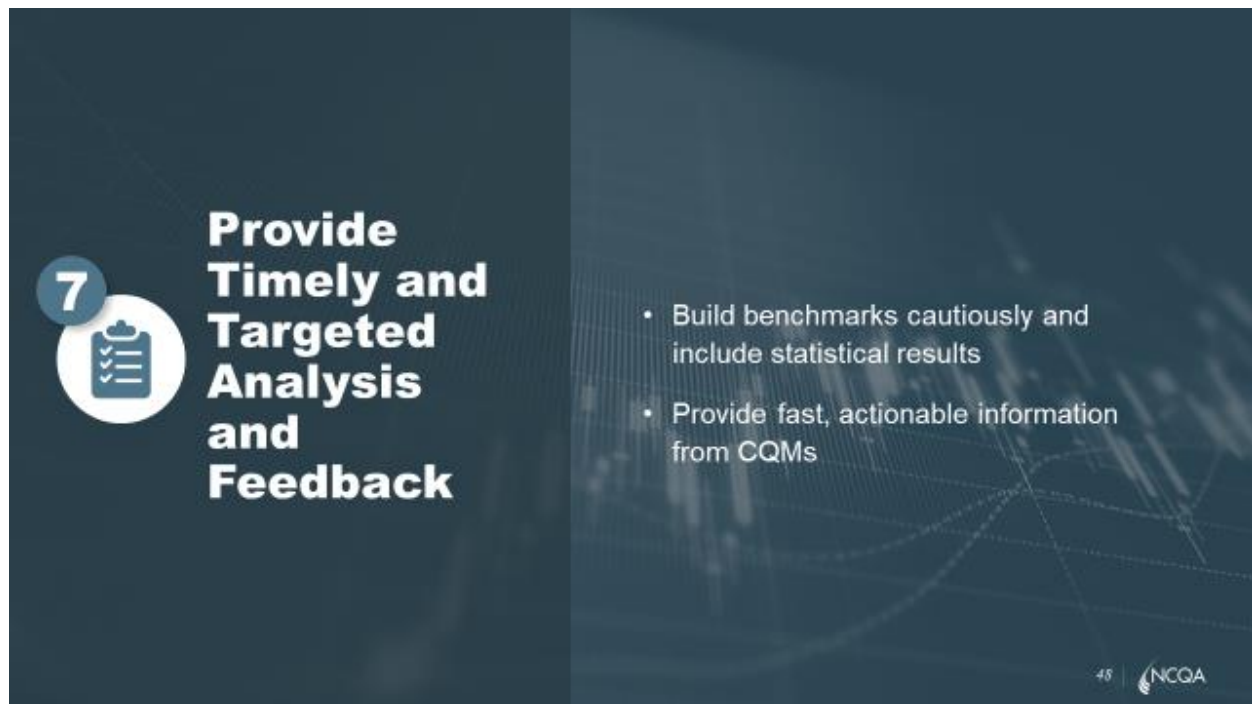
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We want to make sure that everything we're doing is very transparent to those interested in QI, but also those who are interested at the policy level. To understand how to use this information for value-based care, how it can support informed decisions, 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.





528 Ben Hamlin: And finally, we're really trying to shift quality measurement to be much  
530 more prospective. To do that, we must really think about how this  
532 information can be used appropriately, but also when the information  
534 could become available. We don't want to produce information willy-nilly  
536 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.





- 538 Ben Hamlin: So how do we go about doing this and how do we engage our  
 540 stakeholders in doing this? We've had, as Emily has pointed out, several  
 542 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](http://www.ncqa.org/dmc)**  
 or email  
**[digital.measures@ncqa.org](mailto: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

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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.

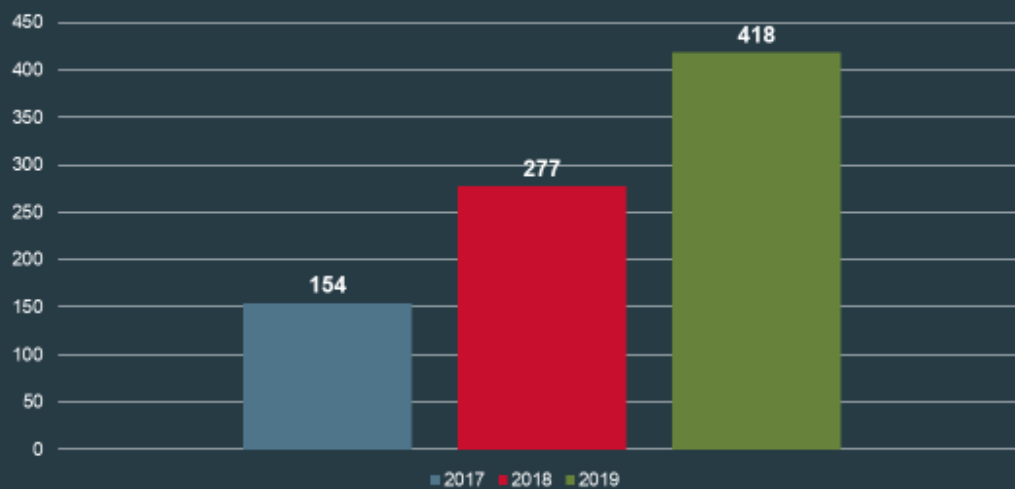


## Digital Quality Summit

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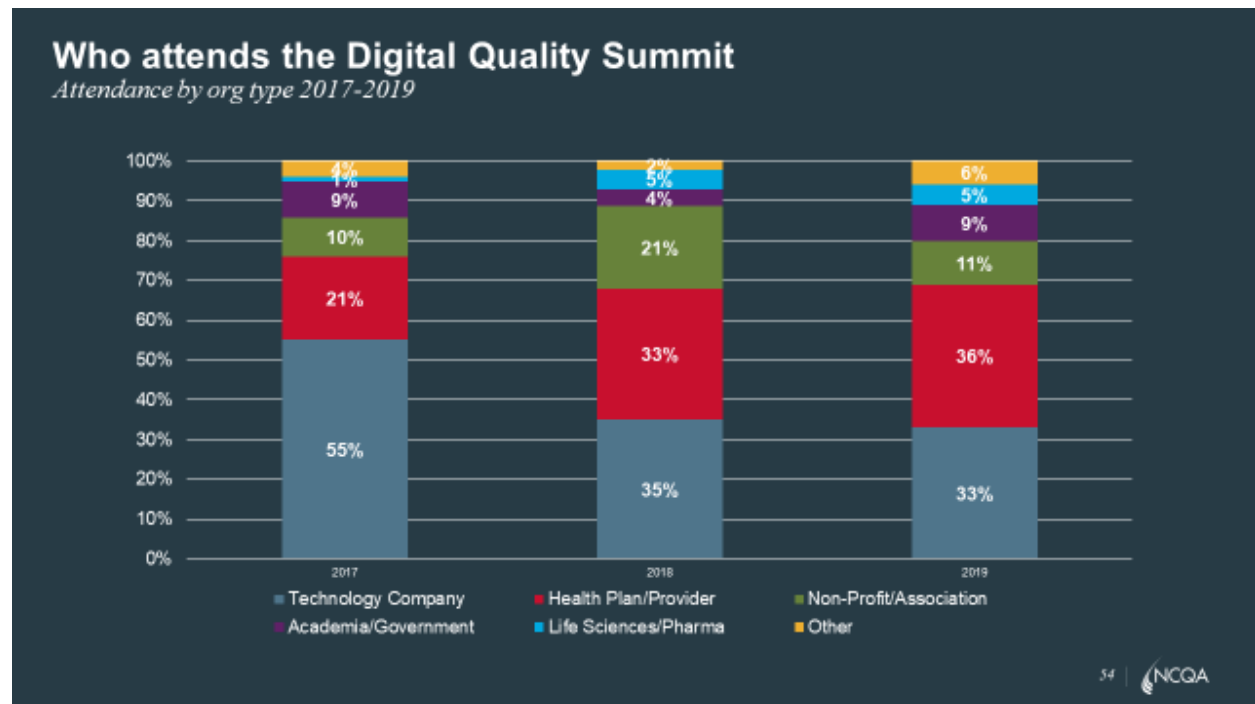
### The Digital Quality Summit has grown quickly

*Registrations 2017-2019*



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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.





570 Ben Hamlin: This event is only three days long, so, if you come up with an entire  
572 roadmap and recommendations in three days—especially when starting  
574 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.

576 Ben Hamlin: It'll be a fantastic event. It's going to be very hands-on. It's going to be  
578 very collaborative. It's going to be very cross-functional. So, we're going  
580 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.



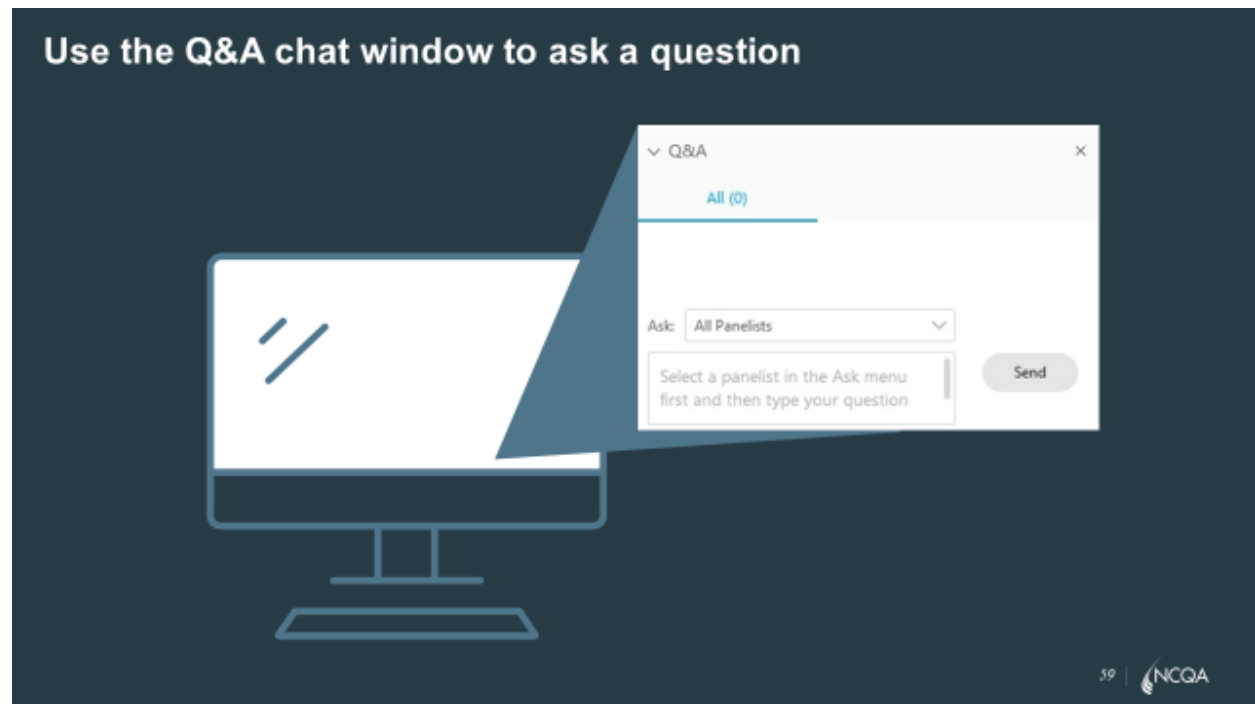


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## How to ask questions after today's Q&A







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](https://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](https://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



608 things that matter. In other words, do all five topics support burden  
reduction, accuracy and measures that matter in the same way.

610 Michael Barr: I think they do relate in different ways. I think that was a great question  
612 because Allowable Adjustments allow you to use the same measures that  
cross the different systems and measure the same way you use the same  
614 clinical logic, same specifications, but take out the attribution model. So,  
from a perspective of what measures should I use at a clinician or  
616 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  
618 reducing the variability to making sure how you use them as accurate.  
And the digital measurements, depending upon the readiness of the  
620 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  
622 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  
624 implementing Digital Measures. Where previously [it] would take 50 to  
100 hours per measure to manually program, they were able to  
626 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  
628 clear, but the time savings is real in terms of implementation.

Michael Barr: Then, of course, certification. Make sure that you're accurately  
630 implementing and producing the correct measures. So, there are a variety  
of different ways. This is the foundation for the future of measures. Once  
632 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  
634 measures would be very different. Much less. And lastly, get to more  
clinically relevant measures. We're talking about several years. These are  
636 building blocks here.

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

Ben Hamlin: That's an interesting way to put it. Yes. So, you must understand that  
642 ECDS, like other domains in HEDIS, including our Effectiveness of Care  
set, is not just about the measures themselves, but [about] the reporting  
644 requirements, the program requirements, the data rules and everything  
else wrapped up. So ECDS are in fact digital measures and they are  
646 probably on steroids. I mean they are complex measures that require that  
digital specification in order to really function well because they're so  
648 complex and they're so involved. But they are in fact part of our digital  
measure portfolio.



650 Ben Hamlin: So, we have 8 digital versions of traditional HEDIS measures that are the  
652 Administrative Specifications, expressed in a digital format. And we have  
654 11 ECDS measures, which are digital measures that follow the ECDS  
656 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.

658 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?

660 Ben Hamlin: Sure. the ECDS data rules and the data reporting requirements were built  
662 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  
664 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  
666 data because we didn't have good rules—or really, standardized rules or  
requirements—around this. The whole architecture of ECDS has  
668 developed to try and not only encourage more use of this data, but more  
standardized use of this data.

670 Ben Hamlin: We wanted to provide a way to better utilize this information and not have  
672 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.

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

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

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

684 Ben Hamlin: Well, I think that we have two certifications right now: one for e-measures  
686 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-  
688 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  
690 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



692 this information that's used for quality assessment is consistent, valid and  
reliable.

694 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  
696 change. How we certify our vendors may change. We may enhance our  
certification programs 10-fold in order to accommodate this new  
698 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.

700 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  
702 for the government?

704 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  
706 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  
708 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  
710 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  
712 others, as we're trying to do through this webinar and other  
communication strategies with the external environment. So, it wasn't just  
714 us developing those; it was in concert with others. And we hopefully we'll  
publish and get some more feedback on the status.

716 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  
718 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.

720 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  
722 feedback. We thought it was time to put something out that was a little  
clearer and more evident about what's driving [development].

724 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  
726 FHIR?

728 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  
730 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  
732 the quality domain. There's a lot to learn there so if you only can pick one



734 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.

736 Michael Barr: And the FHIR resources are on...?

738 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  
740 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.

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

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

748 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,  
750 but we're also being very cautious as we're deploying our digital  
measurements strategy. We are looking at FHIR. We are thinking about  
752 measures in FHIR. We are working with CMS about their schedule for  
converting to FHIR because we want to remain aligned with CMS. But  
754 again, I personally and professionally see a lot of utility in FHIR that goes  
well beyond quality measurement. Other organizations such as NIH is  
756 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.

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

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

762 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  
764 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  
766 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  
768 language as the CMS MIPS measures, and that's intentional. The  
vendors that can support MIPS should theoretically be able to support  
770 ECDS because they're speaking the same language. And we're hoping  
that future standardization of more HEDIS measures will allow more data  
772 to be extracted from EHRs more easily.



774 Ben Hamlin: We are working with HL7 through the DaVinci Project to understand how  
776 data exchange could happen between payers and providers, and  
778 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.

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

784 Ben Hamlin: Well, this is interesting. You wouldn't want to take the HEDIS ECDS  
786 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  
788 individual screening of a depression screening tool being applied. And a  
score for that tool for each individual person.

790 Ben Hamlin: The core clinical logic of who should be screened and when they should  
792 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  
794 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  
796 that's where the program differentiation comes. So, for MIPS, you would  
report a different attribution logic on the front end of that.

798 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.

800 Ben Hamlin: But the fact of who had the screening and how they can transmit that  
802 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  
804 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?

806 Ben Hamlin: So, who should be screening and how the information about who has  
808 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  
810 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  
812 different variables in the measures.

814 Andy Reynolds: Are the measure year of 2020 and measure year of 2021 specifications  
going to be similar? I think this question refers to—



816 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.  
818 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.

820 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.

822 Ben Hamlin: Well, we're working with large vendors to understand the presence of  
824 standardized codes like LOINC in their systems. What are they  
collecting? But that is also part of our measure development process.  
826 When we have a need for a new code to define, for example, for our  
Unhealthy Alcoholic screening, a specific standardized question that you  
828 would want to have a standardized terminology for. We're working with  
Regenstreif to propose those codes and going through that approval  
830 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  
832 it's the standardized terminology, everyone can use the code for all their  
other programs.

834 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  
836 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  
838 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  
840 specific purposes. Like as intended for use as observational data,  
observational clinical data, clinical observations.

842 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  
844 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  
846 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.

848 Andy Reynolds: We still have a few questions and more than 400 people on the line, so  
850 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  
852 Quality Congress (HQC) where the PCMH Congress on the other? What  
kind of person should attend both or that kind of event?

854 Michael Barr: The PCMH Congress is really oriented around the Recognition  
programs—you would say about primary care specialists, the  
856 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



858 will be on the programs and what's happening around the country about  
860 Recognition. And the Health Care Quality Congress. There is a growing  
interest there about what we're doing in HEDIS and the ECDS.

862 Michael Barr: And we have done some presentations there on this topic that have been  
863 well attended and well received. I think the Digital Quality Summit is a  
864 different kind of meeting where we have stakeholders from across the  
range, as you saw in this bar graph. And that diversification is continuing.  
866 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  
868 meetings. Certainly, their engagement and conversations in the hallway  
at the PCMH Congress and HQC. But those are more structured and  
870 people are working more closely together on a topic in breakout rooms  
and the Digital Quality Summit. So, I think they are complementary;  
872 maybe some overlap in terms of interested personnel. But [it] really  
speaks to different types of activities.

874 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  
876 around data exchange, which would then involve the payers and the  
providers, or ECD measures of providers, from these two different entities  
878 to understand how they would facilitate this, moving forward. So again,  
the summit is a very different meeting. It's not your traditional scientific  
880 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  
882 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.

884 Andy Reynolds: Well, it's like we're coming up on a quarter after the hour, so why don't we  
886 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?

888 Michael Barr: That's an interesting idea. And to our knowledge, there are no current  
890 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.

892 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.

894 Michael Barr: And I should have said that, so thank you.





896 Michael Barr: All right; well, thank you very much, everybody. We really appreciate you  
898 sticking with us and through persevering through the technical difficulties  
900 earlier. Thanks to David at WebEx for helping us do this and thanks to the  
902 whole team—Emily, Ben, Andy—for making this work. Look for the future  
904 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.