NCQA

Telehealth and the Future of Quality

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Please note: This transcript has been lightly edited to facilitate reading spoken statements in writing

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Speakers

Peggy O'Kane, NCQA President
Michael Barr, NCQA EVP, Quality Management and Research Group
Brad Ryan, NCQA, Chief Product Officer
Andy Reynolds, NCQA AVP, External Relations & Communications

Peggy O'Kane (00:00): Thank you so much and welcome to our audience. We have a lot of people on the phone and I hope you'll enjoy this webinar.

Facing facts about the pandemic

Quality more important than ever

14	Peggy O'Kane ([00:13](#)):	We're at a moment of great trauma and opportunity in American health care. We've been through a lot; it's not over, and I just want to say that quality is more important than ever. We know that quality isn't perfect in this country, and in fact we found out that it was actually worse than we thought it was, in some ways, in terms of disparities. So, this little girl standing outside Wall Street represents, to me, the kind of determination that we have to show in order to push through to the new way that quality has to be conceptualized in the era of COVID.
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22   Peggy O'Kane ([01:03](#)):   I think one of the more shocking aspects of the pandemic has been the disproportionate illness and death in racial subgroups and the unacceptable gaps
24   in care. This has been something we've been aware of in health care for a while. NCQA is proud of the work we've done in the area, but we need to redouble our
26   efforts and sharpen our strategy because we have a long way to go before, we can feel good about equity in American health care.

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30   Peggy O'Kane (01:43): So, why are we changing HEDIS? You've heard this before if you've been at
these webinars. Well, the health care environment has changed—and even pre-
32   COVID, the health care environment had changed quite a bit. One of the most
important opportunities that presents itself is that we now have data in the
34   delivery system, but the data is locked up. It's hiding behind walls, and one of the
more important things that we have to do (and NCQA has taken this on), [is]
36   break down the walls between the data and get the data to serve the interests of
American patients and practitioners.

38   We also have been getting feedback from you about why aren't we using the
data better and about some of contortions that we've had to go through to get
40   useful and important quality information out of the old sources of care. We've
been doing market research to understand, and we are familiar with the current
42   state of data.

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Peggy O'Kane (02:52): What we know is there are wide disparities across the country in terms of
46 readiness to use electronic data, but we need to push forward. Again, we need to
be determined because there is just a wealth of information and learning and
48 improved performance that is waiting to be unlocked.

Peggy O'Kane (03:15): We want to improve the utility of HEDIS and we want to maintain the integrity of
50 measures throughout the system, but again, we want to use data that is there
already within the delivery system. We want to make a situation where data that's
52 [created] in the production of care can be used for quality measurements. It's a
big goal and it's going to take more than NCQA to get this done, but we think it's
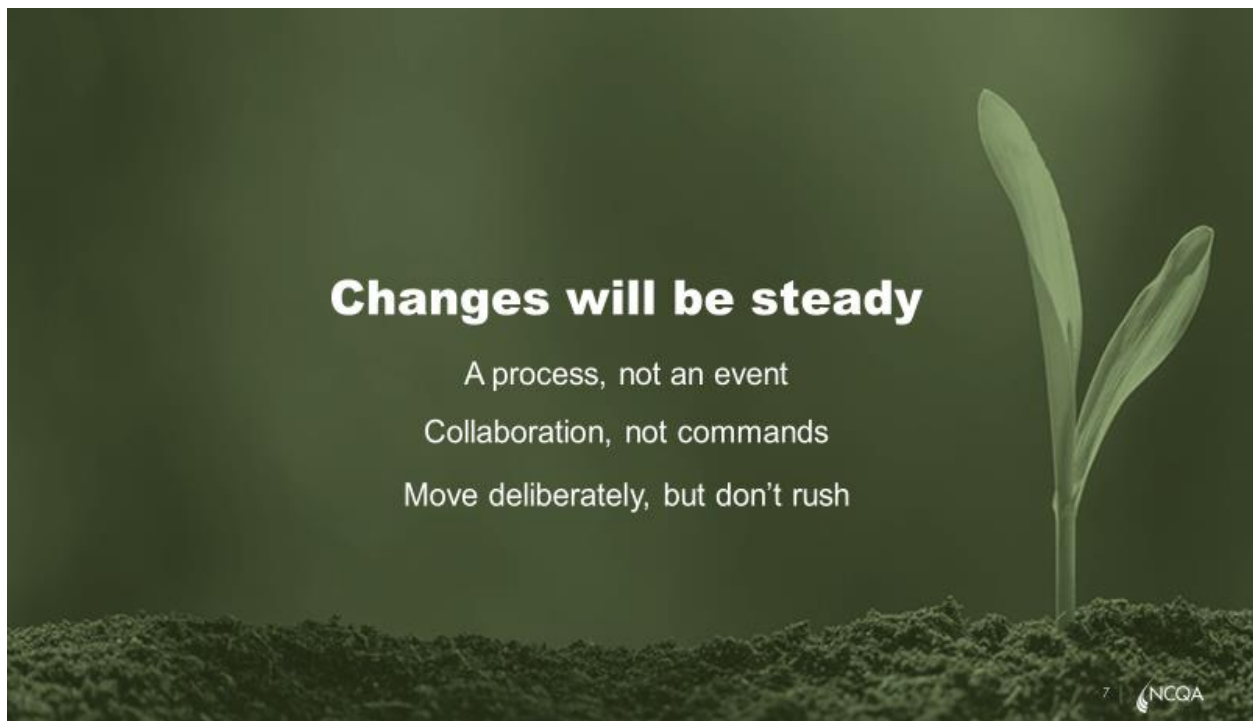54 so important that people will get behind it.

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Peggy O'Kane (04:07): Of course, we don't have all the answers. Nobody does; but in my experience,
58   when you really start pushing for something that makes sense, very often you get
                        there, or you at least get further ahead than you were.

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62   Peggy O'Kane (04:22):   I wish we could be there tomorrow, to be honest with you, but we are realistic
                              about what we confront out there, so changes will be steady. Change will be a
64   process, not a single event. It requires collaboration. We're not in a position to tell
                              everybody what to do. We need to move deliberately, but those that want to
66   move faster, we'd love to work with you and it won't be [at] one pace of change.
                              There will be different paces of change, depending on the situation.

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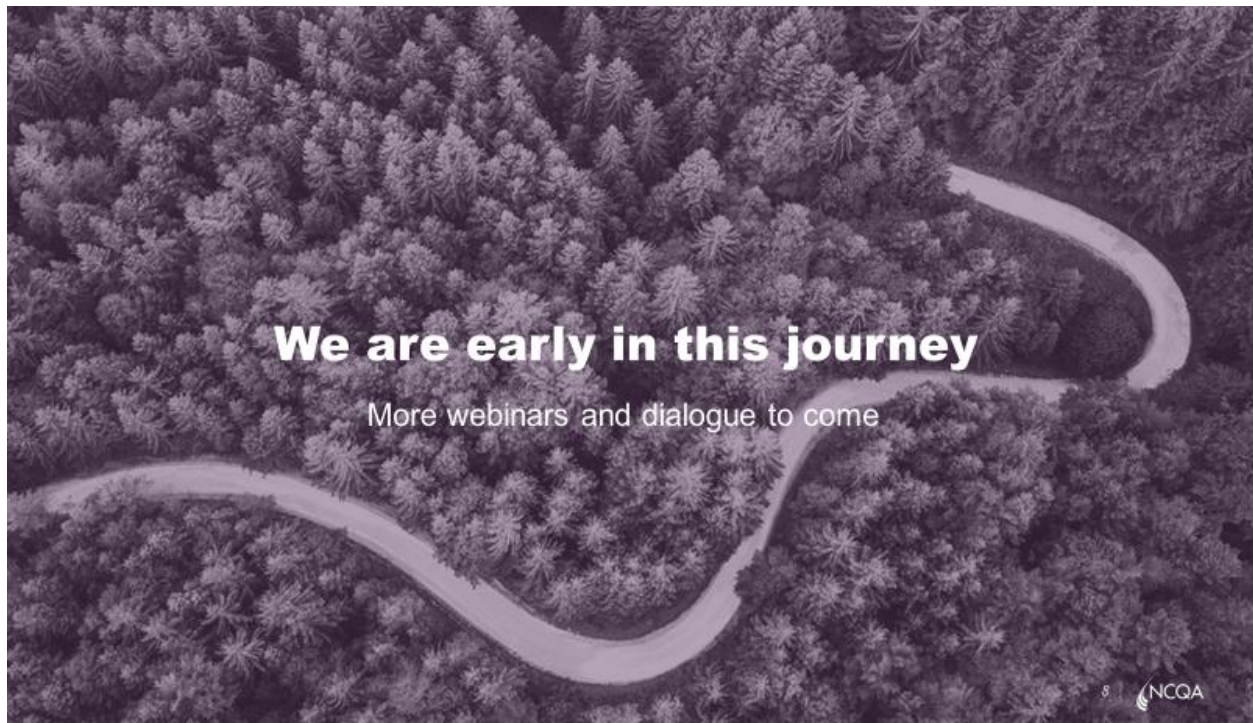
70   Peggy O'Kane (04:59):   We're early in this journey and there's more of this discussion and dialogue to
                              come. With so many people on the webinar today, we won't be able to have
72   dialogue with all of you, but we have some exciting new ways in which we will be
                              communicating with you and really opening up [a] much better understanding
74   both ways in this very important journey.

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Peggy O'Kane (05:27): I want you to meet someone who's going to help us chart our new path. We're
very excited to introduce our new Chief Product Officer, Brad Ryan. Dr. Brad
Ryan has been on the NCQA team now for two months. He comes with a very
distinguished background, which I'm going to ask him to tell you a little about. He
has a big vision for health care and information, and we're thrilled to have him on
board. Brad, take it from here.

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Brad Ryan, MD
NCQA Chief Product Officer
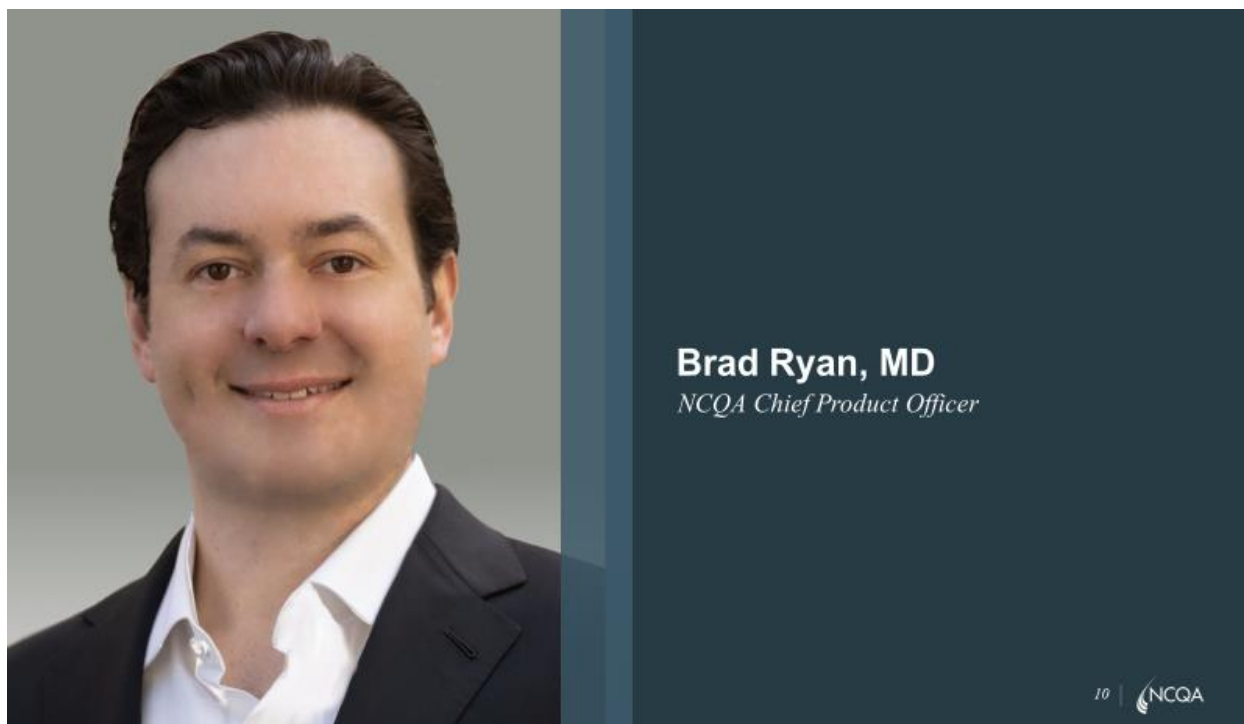
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Brad Ryan (06:07):   Thanks, Peggy, and thanks to all the attendees for giving us time on these important topics today. Very excited to join the team at NCQA to lead product space—meaning our existing products, how we evolve them, and also new products such as digital quality, telehealth and virtual health topics that we'll touch on today.

Brad Ryan (06:34):   As Peggy mentioned my background, I started as a physician, but I left clinical practice early in my career to work in health tech. I had an engineering and computer science background and as I got into my residency, I recognized that I wanted to work *on* the system of health care rather than *in* it; and specifically, work on ways to leverage technology to help improve the quality and the delivery of best practice care everywhere, and [I] have worked towards that end in a few capacities: management strategy consulting at McKinsey and Company, working with a broad range of health care stakeholders on corporate and commercial strategies for digital health. We didn't always call it digital health in those days, but technology and tech-enabled services business.

Brad Ryan (07:33):   I then was an entrepreneur, meaning I ran a growth business inside a larger company at IMS Health, which is now part of IQVIA. I led the Payer & Provider Solutions business there, which were SaaS-based (Software as a Service) product offerings for health care providers and payers that leverage big data and analytics. Then most recently, I was an entrepreneur, co-founder of a digital health company called Apervita, out of Chicago, where we did a lot of work in computable health guidelines and digital quality solutions on products. So my background, I think, is very relevant to the discussion we'll have today and that we'll be having, as Peggy mentioned, over the coming months and years as we—as a company, we as an industry, and you all as stakeholders—go through

110   some of the transformation to digital. Very excited to work on this opportunity with
             you. Thanks.

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114   Peggy O'Kane ([08:46]):   Thank you. Now it's my pleasure to introduce Dr. Michael Barr, who will give us
                                the meat of the presentation. Thank you all for being here. We look forward to
116   your questions and dialogue.

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Michael Barr (09:00):   Thank you, Peggy, and thank you, Brad. Wow, great crowd. I'm looking at the
120   numbers here. We have over 2,800 people registered or online right now, so
                           welcome to episode six of the Future of HEDIS webinar series.

122   Over the course of this webinar series—the most popular series in NCQA
                           history—thousands of people have registered. With each webinar, almost 50% of
124   people have been new each time overall, although today it is closer to 33%. It's
                           good to see a growing number of people interested in these topics and because
126   we understand so many people watching today are seeing this information for the
                           first time, we're going to recap the basics of what we've covered in prior
128   webinars.

                           We suggest that if you need more details, listen to some of the earlier webinars
130   in the series, where we spend more time on each of these topics. For those of
                           you who have attended previous webinars, we hope the first part of today's
132   presentation will be a helpful refresher.

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Michael Barr (10:08):   Previous episodes are posted on our website at the web address you see here,
136   **www.ncqa.org/future-of-hedis**, and we will email slides from today's webinar to
                         everyone who registered for the event and post the slides on our website later
138   today, and in a few days we will also post a recording of today's discussion, and
   a transcript will be up in about a week.

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142   Michael Barr (10:29):   Okay. To the quick recap of our prior webinars and an announcement of an addition to our Future of HEDIS family. We said in the previous webinars that the
144   Future of HEDIS covers five topics, or themes, and now there are six, as shown here from left to right. Allowable adjustments, licensing and certification, digital
146   measures, electronic clinical data systems, reporting or ECDS and a change to the HEDIS publication schedule. Today, we introduce a sixth topic critical to the
148   future of HEDIS. It's in yellow on the far right, and that's telehealth.

      Michael Barr (11:08):   Use of telehealth, as you all know, has surged during the COVID-19 pandemic
150   and brings many benefits, and very importantly, access to care that otherwise would not occur. Telehealth is here to stay and [I] believe it should be integrated
152   into the health care system to support quality, value, access—now and, of course, when we are beyond the COVID-19 pandemic. So, from now on, NCQA
154   will think and talk about the future of HEDIS in terms of all six of these things. I'm going to review the first five original themes and then spend more time on
156   telehealth.
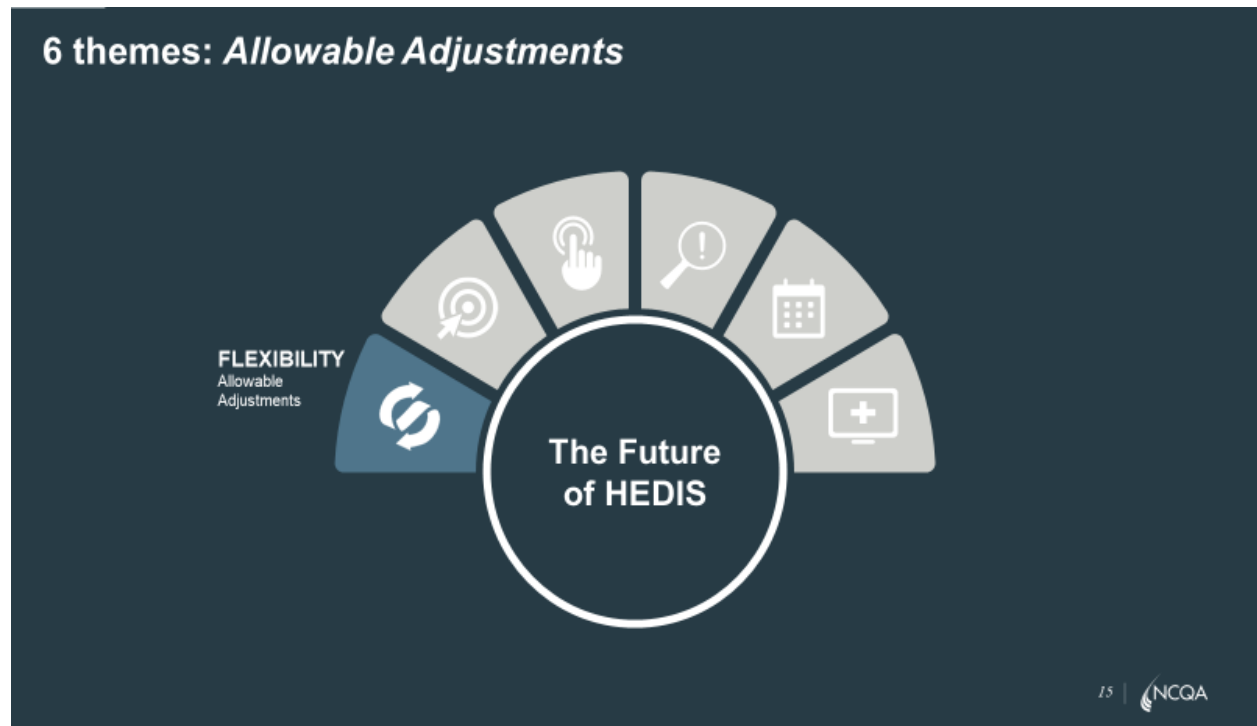
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Michael Barr (11:46):   Let's talk about allowable adjustments. We know people want to use HEDIS

160   measures for purposes other than health plan reporting. HEDIS allowable
                         adjustments were designed for this reason. Allowable adjustments provide the

162   flexibility to modify certain aspects of measures without undermining their clinical
                         integrity. Narrowing a specified age range or focusing on a specific subpopulation

164   within the specified eligible population are two easy, quick examples. Another
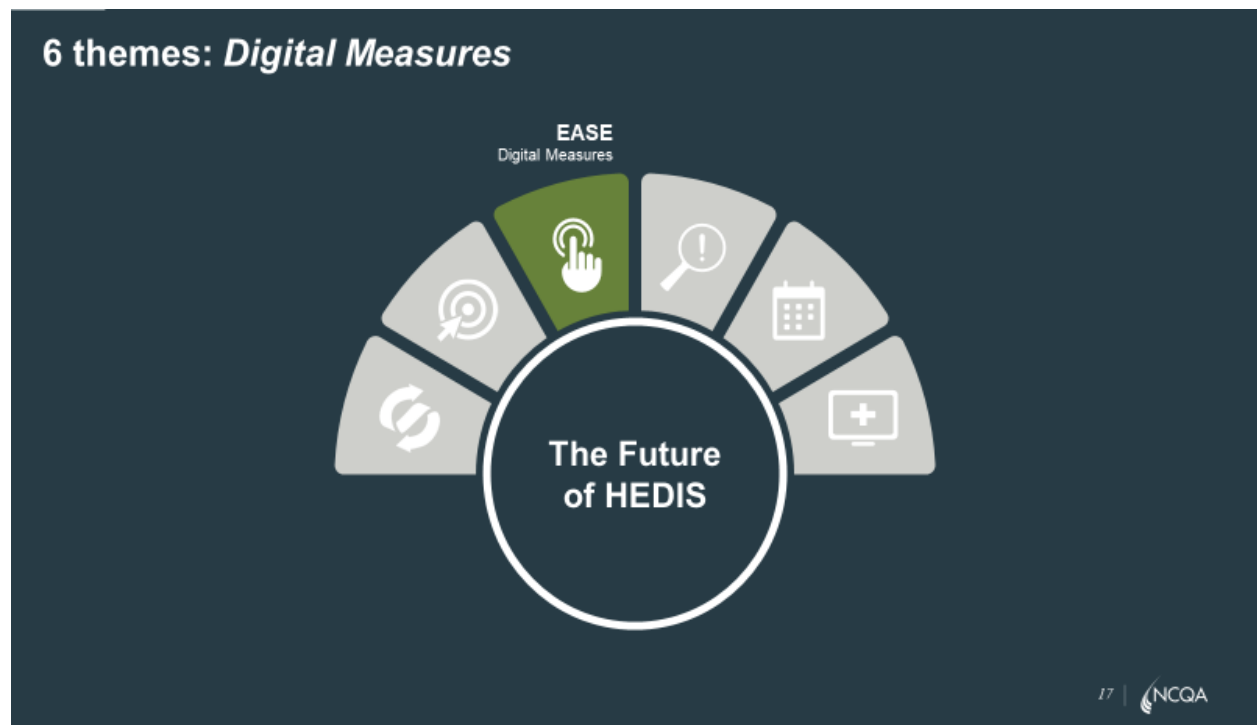   would be turning off continuous enrollment requirements.

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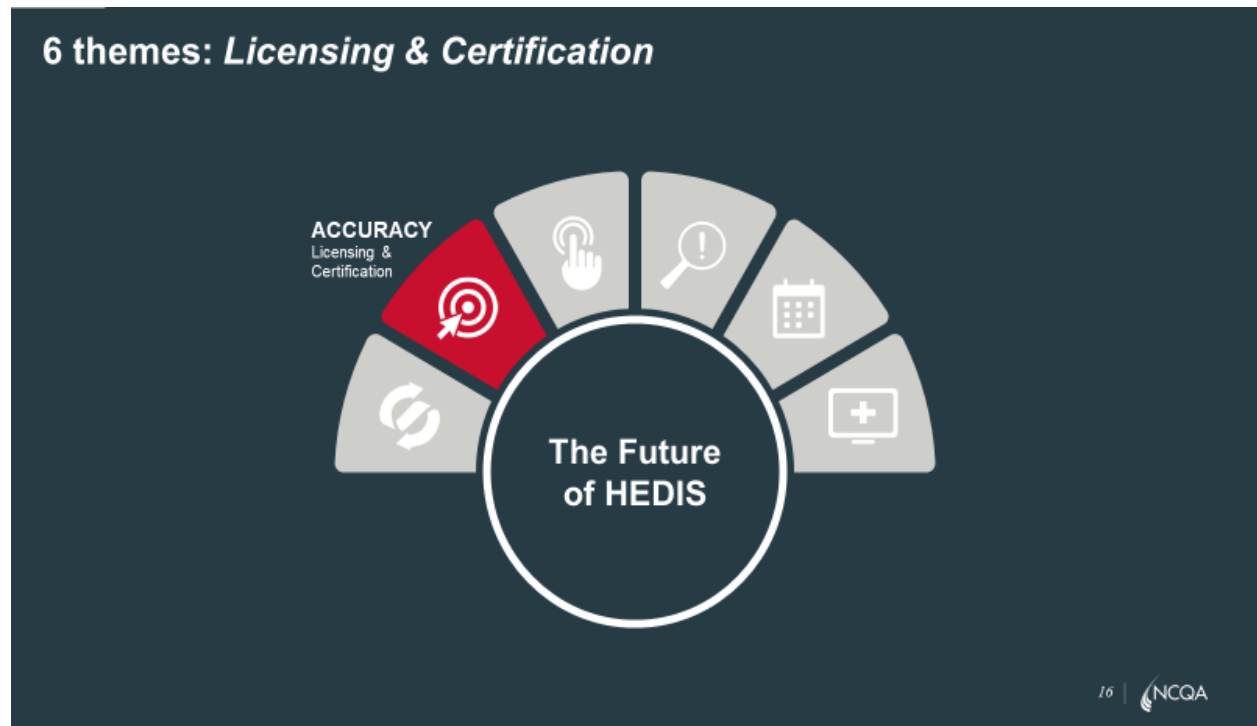
168   Michael Barr ([12:17](#)):   Licensing and certification provide the accuracy needed to make sure the use
                                      and output of our measures reflect the quality of the care provided.

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172	Michael Barr (12:27):	With digital measures, we write measures as computer code so you don't have to. Using digital measures reduces human error, implementation time and non-standardization. NCQA digital measures are downloadable and machine readable from the NCQA store. For those organizations that can download the measures directly into an execution environment, the benefit translates into significant cost savings, programming and reduced time to implementation.
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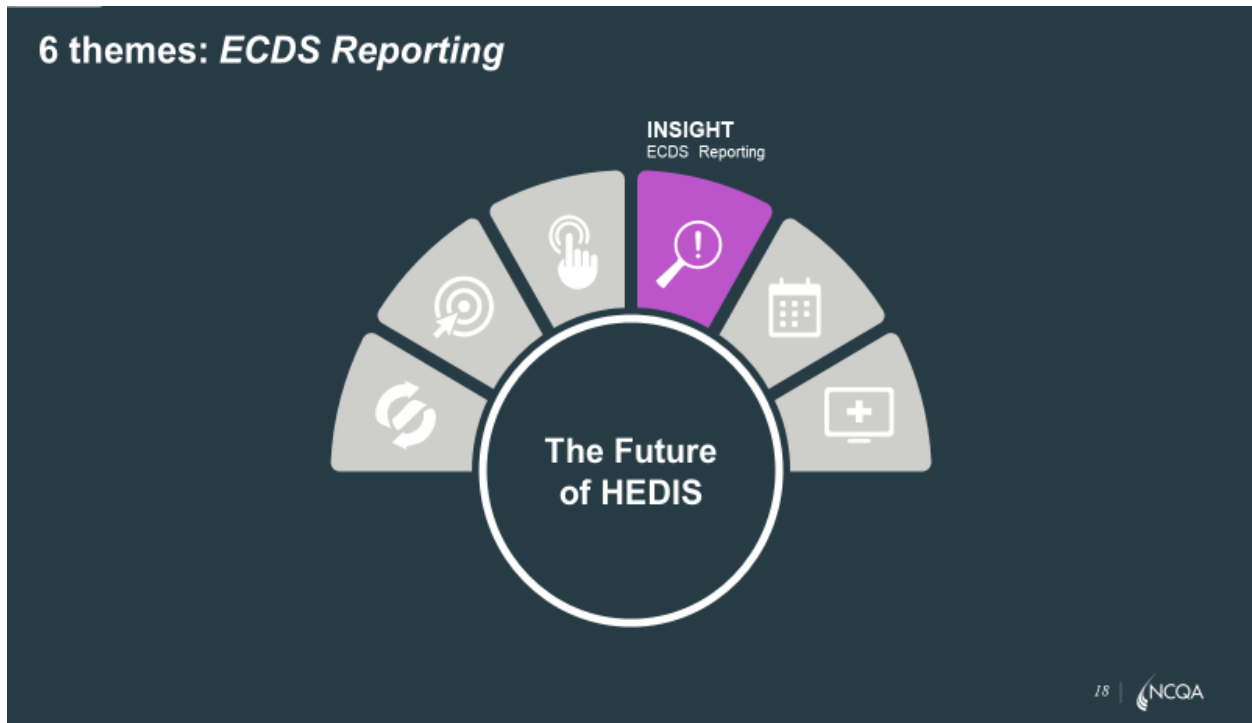
180	Michael Barr (12:53):	ECDS reporting, or electronic clinical data systems, is NCQA's newest reporting method. As digital measures, these have all the efficiencies I referenced on the prior slide. The reporting method was designed to help HEDIS implementers increase the efficiency of quality reporting and to use data and clinical information from many sources, not just electronic health records, to generate new quality insights from data generated as care is delivered.
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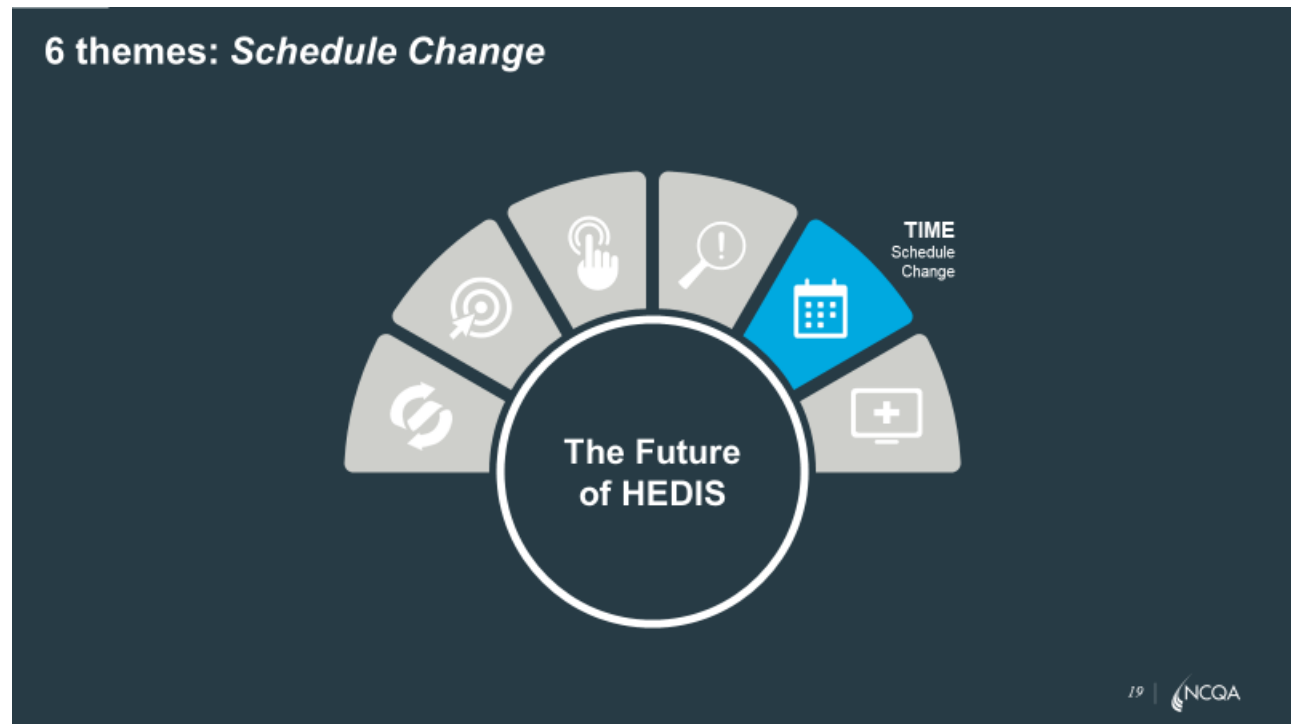
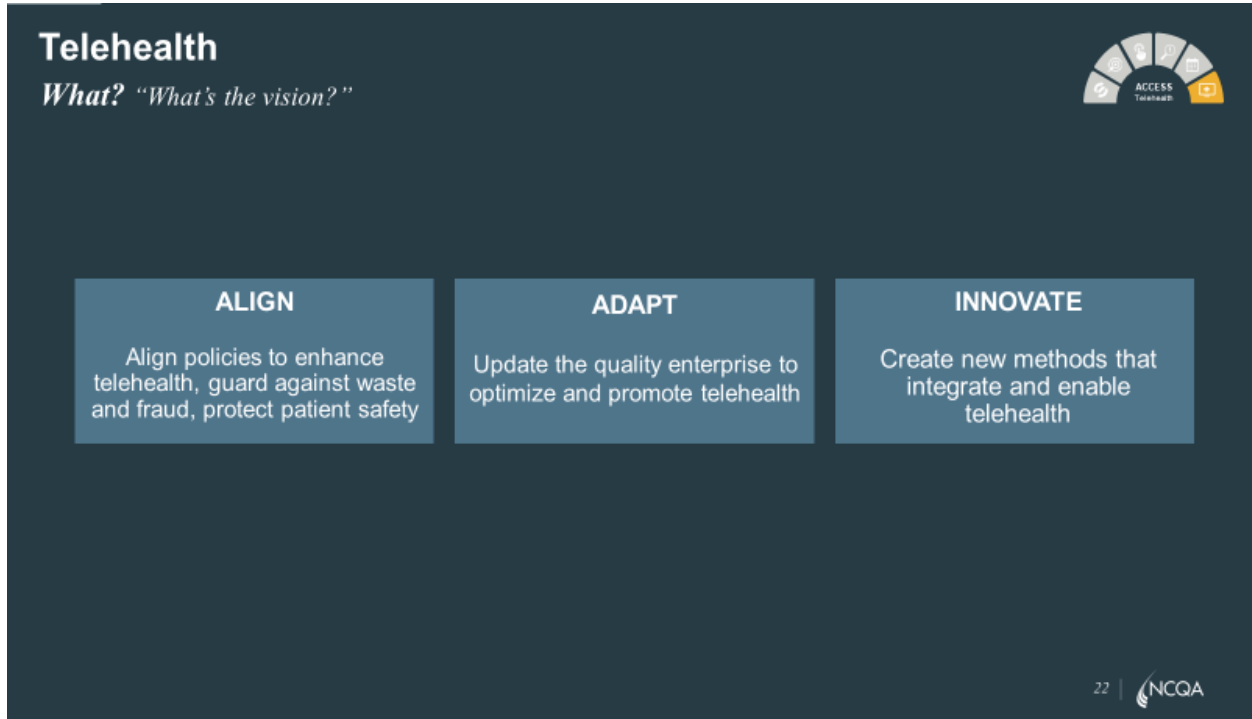| 188 | Michael Barr (13:21): | All right, everyone check your calendar. Is July 1 highlighted? If not, do that now. The HEDIS publication will be released on Wednesday, July 1, two days from |
| 190 | | now, to give you access to HEDIS specifications for Measurement Year 2020 and Measurement Year 2021. More on that later, if this is news to some of you. |
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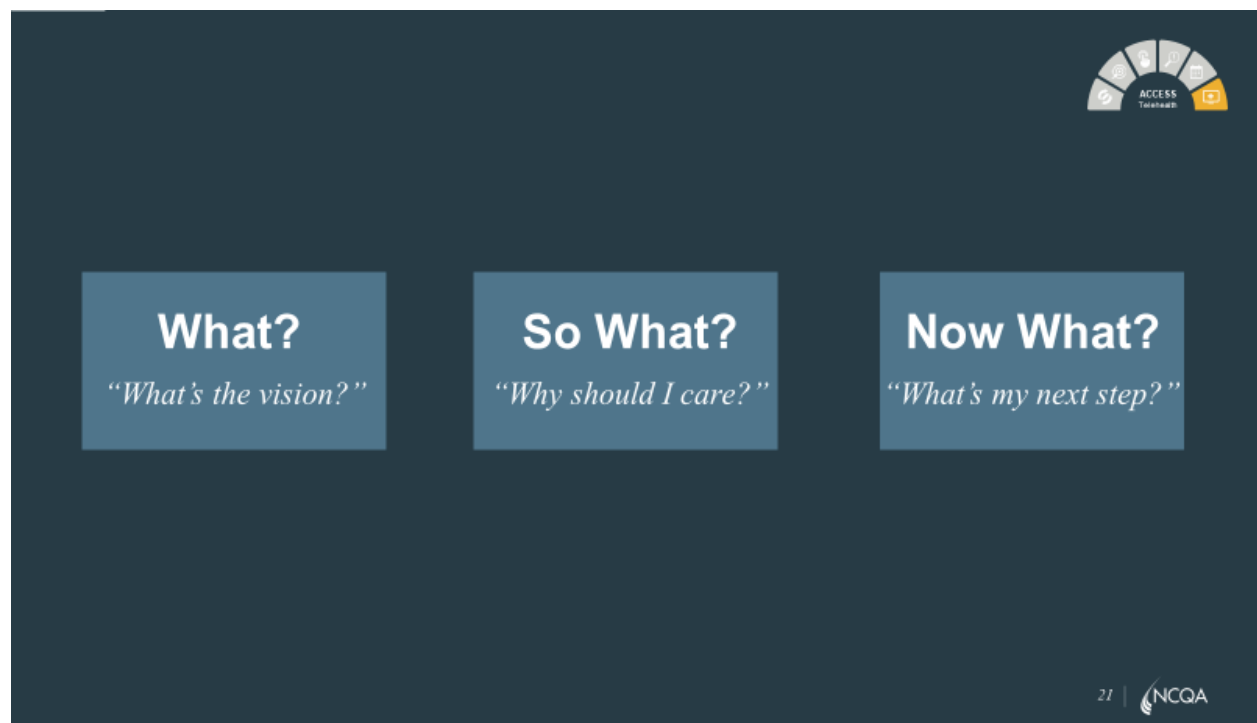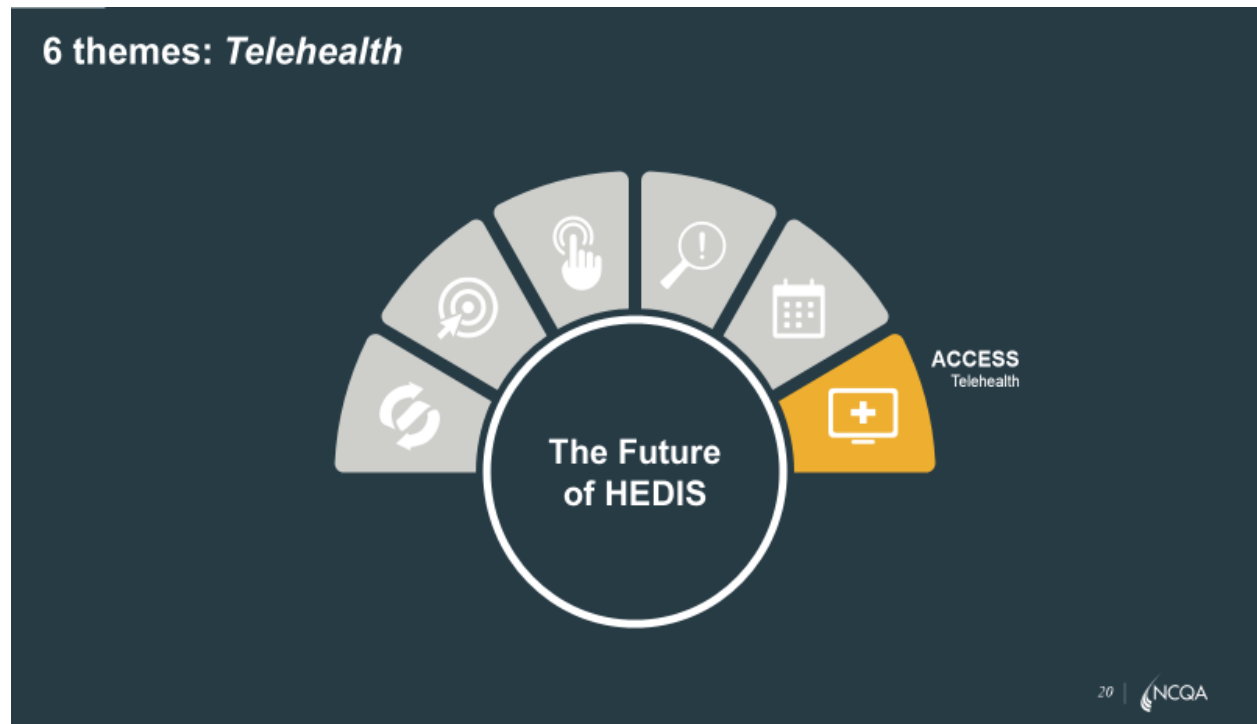
Michael Barr (13:44): Now, let's talk about telehealth, the sixth part of the future of HEDIS. To explain
196 telehealth's role for HEDIS, and for quality generally, I will cover the what, the so
what and the now what. The "what" answers the question, "What's the big idea?"
198 The "so what" answers the question that's always on people's minds, "Why

200 should I care (or what's in it for me)?" The "now what" is about some next steps, both for you and us at NCQA.

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204 Michael Barr (14:16): Here's the "what"; it summarizes NCQA's vision for telehealth in three words: align, adapt, innovate. We are working to align policies that build telehealth into an ecosystem of high-quality care. We're crafting consensus on policies that will enhance telehealth, prevent waste and fraud and protect patients. Our agenda to adapt quality measurement means updating how we measure quality. We want to do more than just accommodate telehealth; we want to help telehealth grow. That's where our desire to innovate comes in. We want to support telehealth's integration into novel ways of delivering care and improving health. We want to help telehealth evolve and support the growing ways in which telehealth can deliver good care and be able to point to good care delivered through telehealth.
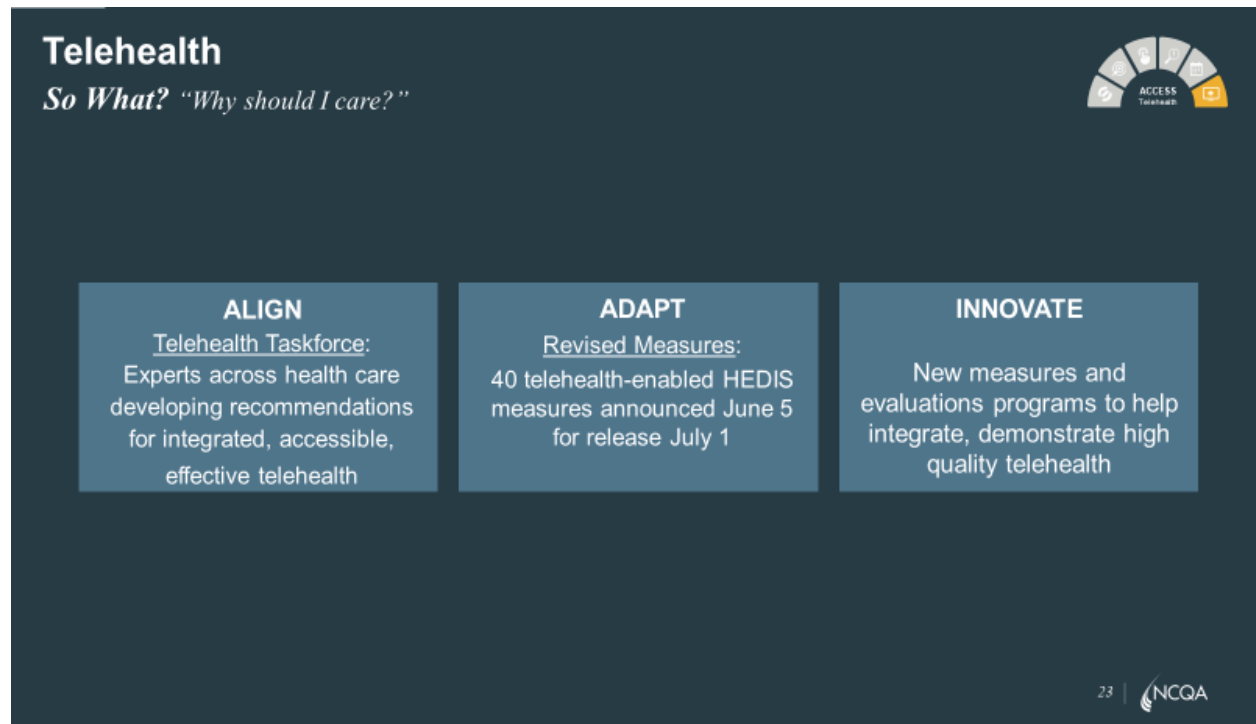
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Michael Barr ([15:02](#)):	At this point, you might say, "So what? Why should I care?" Well, we've already started aligning, adapting and innovating to make telehealth part of high-quality health care. An example of work to align policies is our role as co-convener of a newly formed Telehealth Task Force, which met for the first time today. The task force is an impressive group of more than 20 leaders from across health care, including former Surgeon General, Dr. Regina Benjamin. This summer, the task force will craft policy suggestions that support integrated, accessible and effective help.

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Michael Barr ([15:37](#)):	Our "adapt" agenda means we've updated quality measures. Earlier this month, we updated codes for 40 HEDIS measures to allow greater use of telehealth. Those measures are part of the HEDIS volumes we are releasing just in two days, July 1, Wednesday.

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Michael Barr ([15:52](#)):	Our "innovate" agenda means inventing things you've not seen from NCQA before, and we don't know yet what combination of measures, programs or evaluation frameworks we'll create. We're exploring many things to measure and grow telehealth as part of the value agenda. By the way, when you get these slides, the underlined words are hyperlinks, so you can click on these links to access more information from our website.

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Michael Barr (16:18): Here's how you can know and shape where NCQA is headed on telehealth. First, you can tell the newly convened Telehealth Task Force how you think we should align telehealth policies. Public comment for the task force is open until Thursday, July 9. Tell the task force what role you think telehealth should play in quality health care, then look at the task force's recommendations for September.

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Michael Barr (16:42): Next, the "adapt" agenda. You can adapt or update your understanding of telehealth and other technology by joining our Digital Measurement Community. That's a new online group that launches next month during the Digital Quality Summit, and I'll explain both of those things a bit more in a few minutes; and we're going to give you a virtual tour of the community in a few minutes. It's a great place to expand what you know about telehealth quality and measurement.

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Michael Barr (17:08): Finally, you have a voice in how NCQA will innovate new ways to integrate and support telehealth. If your organization uses telehealth to deliver care, please complete our telehealth care delivery survey. Telling us about your telehealth experiences will help us build telehealth and its new programs. When you take the survey, let us know if you'd be open to giving us advice in a follow-up phone call with our staff.

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Michael Barr (17:30): Again, on this slide as well as on the other slide, underlined terms are hyperlinks. Click on them when you receive the slides and they will get you where you need to go on our website. That's what we recommend as your next steps.

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Michael Barr (17:40): Now, I'm going to turn things over to Dr. Brad Ryan to tell you a little bit more... Brad?

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258 260 262	Brad Ryan (17:50):	Thanks, Michael. This is obviously a very important and timely topic for us. As Michael mentioned, we have several initiatives already underway. Let me say a couple of things first about what should not happen with telehealth surge that we're seeing currently, in resolution of the COVID crisis as we get to [the] next normal, and then say a little bit about what we think should happen and what you can expect from NCQA.
264 266 268	Brad Ryan (18:27):	What shouldn't happen is that while we've made a ton of very quick progress, I've heard it said, and I agree, that we've made a decade's worth of progress in telehealth in a few months. What shouldn't happen is it should not remain the Wild West. It should not remain as wide open as it is today. What also shouldn't happen is that it should not be treated as an add-on or extra new thing. It needs to, as Michael mentioned, be integrated into our overall quality framework, how we think about measurement and compensate for quality as a system.
270 272 274	Brad Ryan (19:11):	That also means another thing that shouldn't happen is we shouldn't throw away all the progress that we've made over the last couple of decades and start from scratch. So, our task as an industry and as an organization at NCQA is to thread that needle between the "adapt" that Michael mentioned and the "innovate," where we do need to build new products and services vs. align those that we already have. And so walking that line is going to be a big piece of this.
276 278 280 282	Brad Ryan (19:49):	The last thing that it shouldn't be, as we sort of work on the telehealth topic, is a situation where we fail to realize all of the promise and benefits that telehealth holds—meaning cost reduction, meaning enabling new models of care delivery. When we think about that innovative work stream, we've got to walk a balance between protecting and maintaining the things that work today and enabling and fostering the innovation that helps us get to a better tomorrow, whether it's virtual or in person.
284 286 288 290	Brad Ryan (20:36):	So what you can expect to see from NCQA, as a starting point, will be a framework for how to think about telehealth and types of telehealth, even [about] what telehealth means to a lot of different people. There are a lot of different types of things that we call "telehealth" and virtual care—everything from a virtual visit, which is a little bit more like a "substitute of something that we know and understand" visit, to things that look completely different, like chronic care patient engagement applications where we're doing something in a different way or we're doing something that we haven't done before, and everything in between.
292 294	Brad Ryan (21:23):	When you think about that framework, think about us being able to talk about the appropriateness of telehealth use by those different types and modalities of telehealth and by care setting and care situation, and then not to just talk about appropriateness, but to talk about quality of care.
296 298 300	Brad Ryan (21:46):	You can expect to see updated products and new products launched by NCQA for Accreditation, quality, payment and incentives that both align with our ongoing digital quality agenda and all the things that we're talking about with digital quality, and some that are telehealth specific, both for the stakeholders that will rely on telehealth with oversight and accountability for their populations, whether they are employers or payers or government organizations, and products for the users and purchasers of telehealth, like the providers and the consumers of it.

302   Brad Ryan (22:28):   NCQA sees ourselves as having a meaningful role to play across some of those
304   spaces, and you can expect to hear from us in a public setting, as Michael talked about in "alignment," trying to bring stakeholders together, foster alignment and drive that alignment through both policy and operations as an industry and with
306   the products that we'll bring to you and your organizations that we think will enable you to both understand and measure quality, but also to improve quality
308   of care and improve the models for compensation and incentives related to quality of care in the telehealth world.

310   Brad Ryan (23:12):   I'll turn it back to you, Michael.

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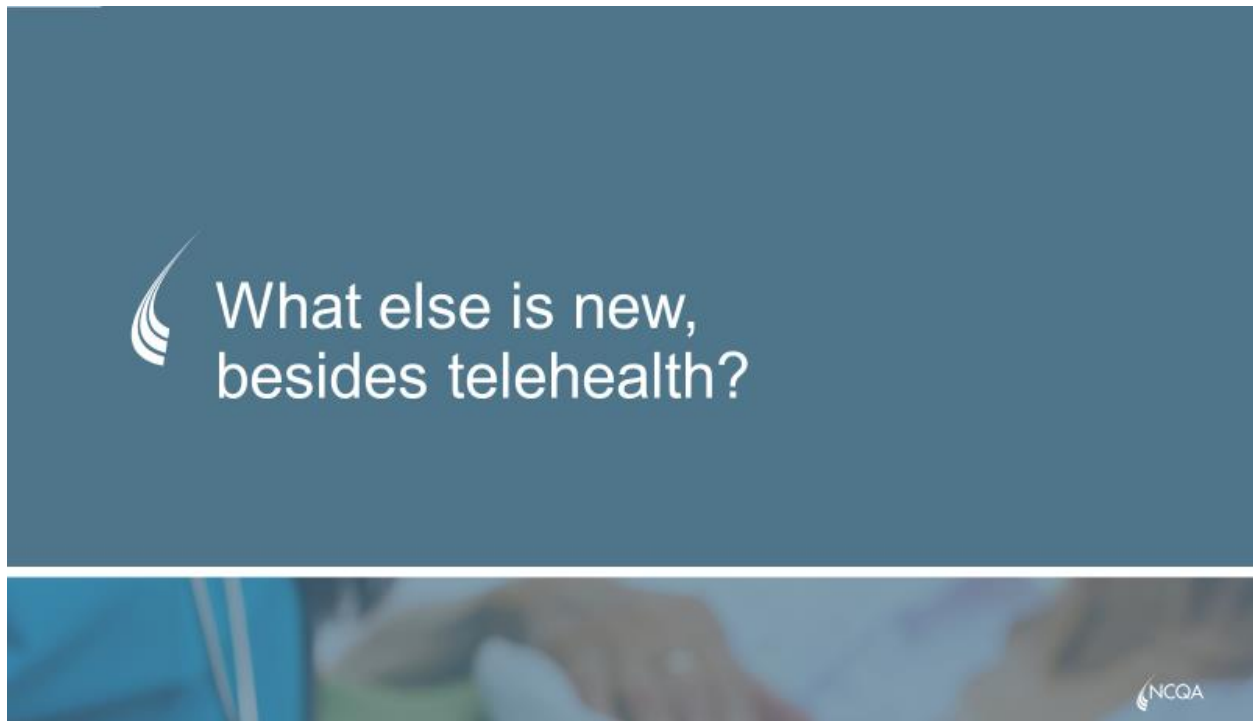
Michael Barr (23:18):   Thank you, Brad. So that wraps it up in terms of telehealth, but what else is new
314   besides telehealth? We have a few quick things we wanted to cover with you. First, there's been some work to clarify important terms. We tried to do this in one
316   of our earlier webinars and hopefully we'll get closer to explaining things. So, let's think about traditional electronic clinical quality measures and the new term we're
318   using, along with others—this is not just an NCQA term—"digital quality measures."

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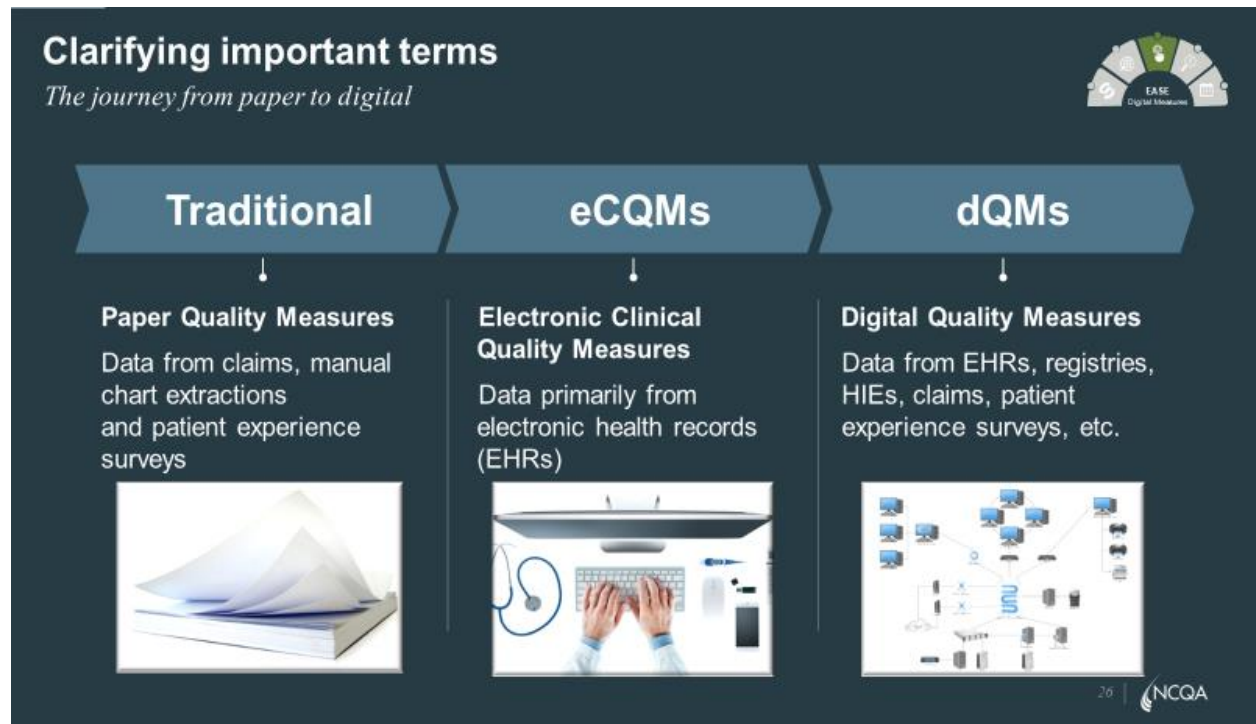
| 322 | Michael Barr (23:49): | Let's start with "traditional." Those are paper quality measures. Collect data from claims, manual chart abstractions or abstractions in patient experience surveys, and those measure, by and large, are narrative based. |
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| 326 | Michael Barr (24:01): | Electronic clinical quality measures—you can think about those as measures in which the predominant source of information is electronic health records and you could think about the quality payment program, or CMS measures, as examples of eCQMs. |
| 328 | | |

330	Michael Barr (24:17):	Digital quality measures are digital measures, but they pull data from multiple sources. EHRs, registries, health information exchanges, claims, patient experience surveys. And for those of you familiar with NCQA's terminology, these are the sources of data for electronic clinical systems data reporting. ECDS reported measures are digital quality measures. eCQMs are digitally expressed but rely upon EHRs. You'll let us know if this helps a little bit in terms of clarification, but dQMs, or digital quality measures, is the language that Seema Verma, CMS administrator, and Dr. Michelle Schreiber, from CMS, adopted during the CMS Quality Congress conference—which seems so long ago, but was only February.
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Unlocked Value Sets

*"This is awesome news! Thank you so much.
I am certain many others will be
super happy about this.*

*I will never forget the time our quality vendor missed putting
in the FOBT code because someone missed typing it.*

Have a great day —you made mine!"

– **Terri Kitchen, Divisional VP, Quality & Accreditation**
Health Care Service Corporation

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Michael Barr (25:08):	Now, for some of you, this is going to be important. Some of you are going to say, "What's that?" Well, with the HEDIS measures, we offer our value set directories, and to date they have been locked. In other words, they're CSV, or Excel spreadsheets, that you cannot really manage or use. For those of you who are interested, they will now be unlocked as of July 1, and Terri Kitchen, who is from HCHS, was asking about this off and on for months. When I told her, this was going to happen in July, the quote of hers is on the slide. "This is awesome news. Thank you so much. I will never forget the time our quality vendor missed putting in the Fecal Occult Blood Test code because someone missed typing it." So, hopefully this will solve some challenges you've experienced in the past.

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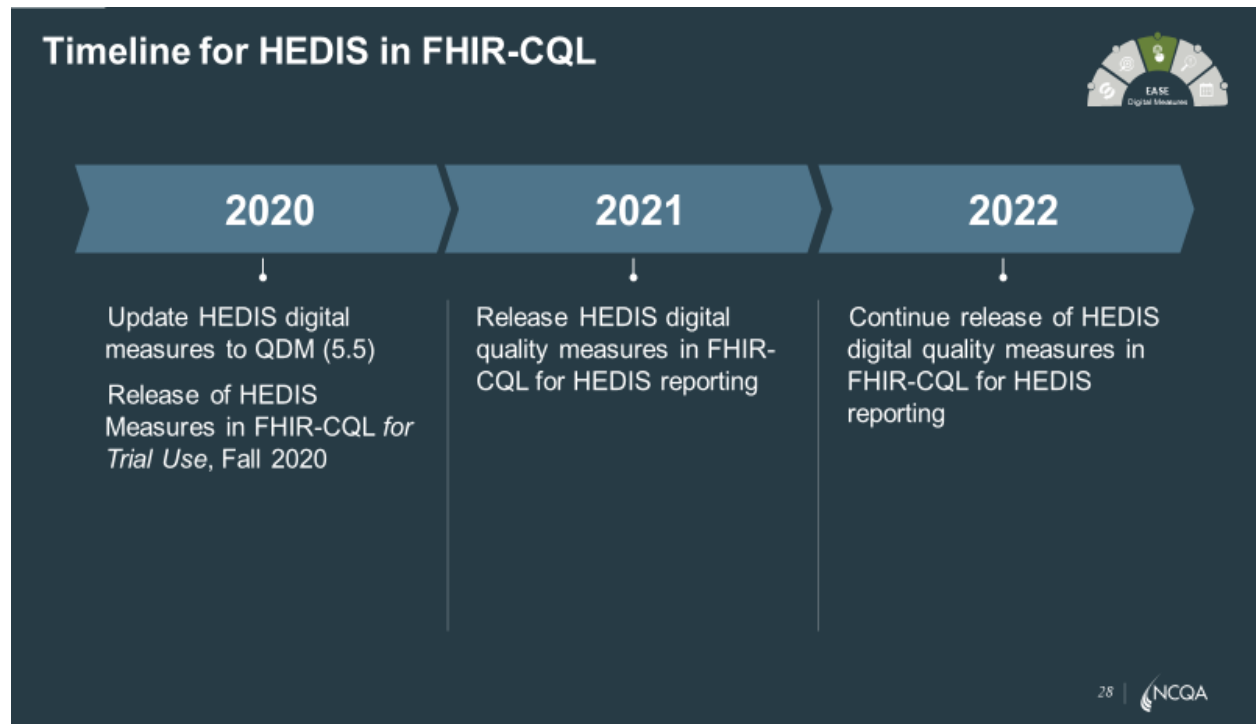
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Michael Barr (25:59):	This group has been really helpful—those of you who have attended the Future of HEDIS webinars in the past and [who are] helping us formulate our FHIR-CQL strategy. As you might recall, we were talking about this a few webinars ago; we were talking about quality data model and the speed with which we might go to best health care interoperable resources.
	Well, here's the current timeline, based upon feedback from some of you and from additional market research. This year, our digital quality measure bundles will remain in quality data model, but they'll be updated to 5.5; and in the fall of this year, we will release a subset of measures in FHIR-CQL (clinical quality language) for trial use. In other words, we do not expect anyone to use those measures for reporting. These are for you to see what those measures will look like and provide us feedback so we can get ready for 2021, when we expect to release all of our digital measures in the FHIR-CQL format for HEDIS reporting. That doesn't mean all the HEDIS measures will be in there, but all our digital measures will be in FHIR-CQL and we'll look forward to doing that and building that portfolio over time. We will no longer release measures in the quality data model, starting next year.

	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

372	Michael Barr (27:20):	Okay, there are many details on this slide. Some of you have seen this before. We urge you to look at them after we email you the slides from this webinar. The
374		most important date's the one that's been circled and the one I said a couple of times already. Two days from now, on Wednesday July 1, we will publish
376		measures that apply to Measurement Years 2020 and 2021. July 1 marks an important transition date in a long effort by NCQA to bring you measures sooner.
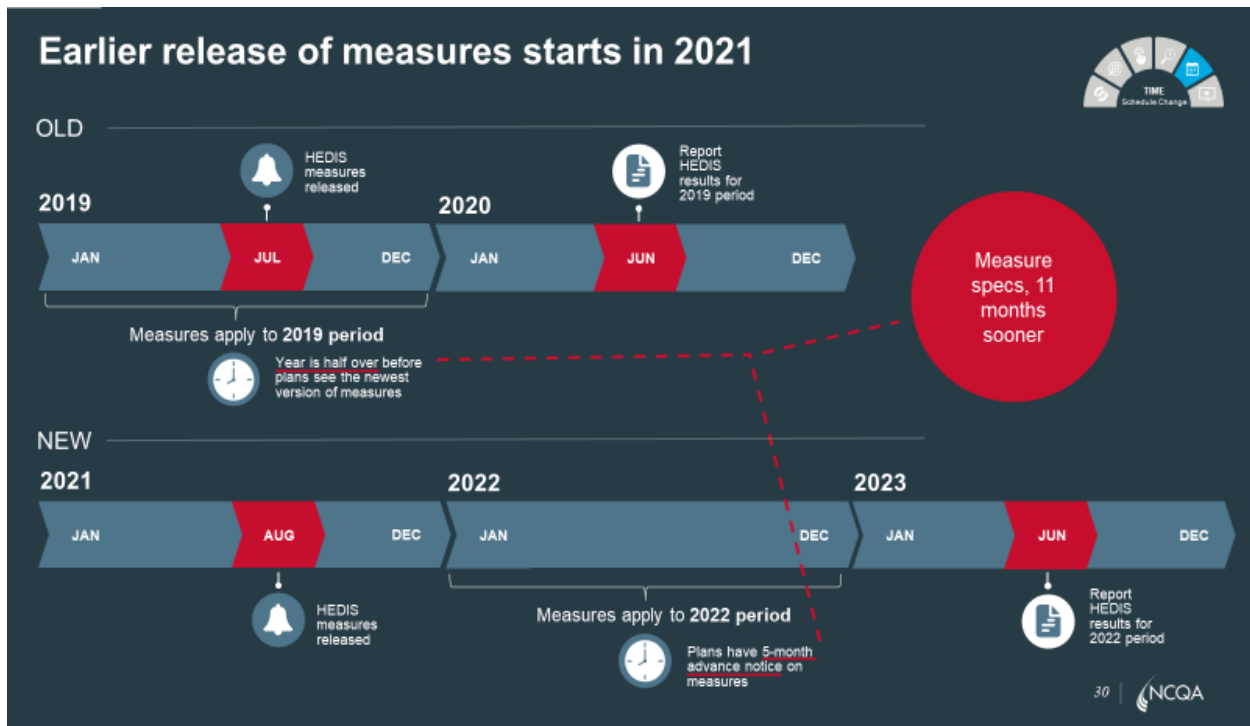
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Michael Barr (27:53):		As you can see on the top half of this slide, our traditional schedule was to release measure specs in HEDIS volume 2 halfway through the year in which the specs are to be used—July. That means the measurement year was half over before plans knew what they're expected to report. This six-month lag has been a feature of the HEDIS cycle for decades.
		Now the new way. On August 1, 2021, we will release measures that apply to services in 2022. Health plans will have a five-month lead time on what the measures will be, and overall this shift in the schedule will bring you certainty about measured specs sooner—11 months sooner than in prior times. This is the transition year, so HEDIS for Measurement Year 2020 and Measurement Year 2021 are being released this week on July 1.
Michael Barr (28:41):		Note that we're not changing HEDIS submission deadlines. Reporting the data will still happen in June of the year after the measurement year, same as it always has.

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Michael Barr (28:54):   Our Digital Quality Summit is just a few weeks away, and we urge you to attend. I've heard there are over 100 of you on this webinar that have already registered for the Digital Quality Summit. I can tell you the registrations are now close to 500 people in terms of people who are attending, that have already registered for this meeting. It's our main annual conference about quality digital future, and this year will, of course, be completely virtual.

Our key speakers include [Peggy] O'Kane; Chuck Jaffe, CEO of HL7; Michelle Schreiber, Quality Measurement and Value-Based Incentives Group Director at CMS; Eric Hargan, Deputy Secretary HHS; Dr. Harold Lehmann, professor of Health Sciences Informatics at Johns Hopkins University School of Medicine; Noam Levey, an *LA Times* reporter; and Danielle Brooks, director of Health Equity at AmeriHealth Caritas.

We have great panel sessions and five engaging tracks from which to choose; look for the announcement in the next couple of days or so, because we just landed two additional, very high-profile speakers, and we'll be announcing that as [soon as] we can. We're just waiting for all the publicity to be approved.

Michael Barr (30:05):   Now on this slide, the blue boxes show the tracks of discussion topics featured at this year's summit. Those of who have been to these before knowing they're very hands-on in the breakout groups. We're going to try to emulate that in these virtual sessions, and so please take a look at these topics in the breakout groups and pick one that you want and join us at the Digital Quality Seminar next month. You can register at **www.ncqa.org/digital-quality-summit**.

418	Michael Barr (30:34):	I mentioned this earlier. During the Digital Quality Summit, we will launch NCQA's
420		new Digital Measurement Community. If you're looking for an online environment where you can learn and contribute to the growth of digital measurement, this is the place for you. Now, we're going to play you a video that will show you around
422		the community. If you're watching this webinar on a phone, you may not be able to see or hear the video. You can watch the video on your own by typing the tiny
424		URL you see on the side or in the chat into your phone, or you can take a break and come back in a couple of minutes when this video is done.

426	Video Speaker (31:19):	Hi. Are you looking for the Digital Measurement Community?

	Video Speaker (31:23):	Come on in. This is a space to share your thoughts and ideas with others. You
428		will learn from each other as you work together. At the top, you find links to our peer group pages. We post new and featured content of interest to members who
430		identify as payers, clinicians, informaticists and policy experts.

	Video Speaker (31:44):	The payer group. This is where we feature information and notices that
432		specifically address issues important to a health plan, HEDIS audit organization, hospital quality department, ACO or integrated delivery network.

434	Video Speaker (31:59):	The clinician peer group. Expect to see and share a lot of practical posts on quality measurement and quality improvement for clinicians.

436	Video Speaker (32:07):	The informaticist group. We cover a broad array of topics on informatics and information technology and health quality.

438   Video Speaker (32:15):   The policy section is for anyone involved with federal agencies, state and local health departments, public health agencies and health care policy.

440   Video Speaker (32:28):   Moving now to the middle of the page: You see this link to the Community Forum? This is where we want each of you to share your ideas, engage in
442   discussions and debates on digital quality and post questions for your peers.

        Video Speaker (32:42):   Finally, at the bottom of the page, you find what's new: the latest and greatest
444   items just added to the DMC.

        Video Speaker (32:49):   Now that you know about the home page, whose page should we visit first? Let's
446   go to the informatics page. At the top, in the red navigation bar, you can find access to the blogs, podcasts and videos from the informaticists drop-down
448   menu. Further down on the page, you see new and featured content, relevant resources and a link to the relevant discussions in the Community Forum. We
450   also include a place to post relevant resources important for understanding digital measurement from an informatics perspective. Here is a block titled, "Where will
452   the Digital Measures Roadmap Lead?" At the bottom, we encourage everyone to share their thoughts in the Community Forum. That's the spot for you to be
454   heard.

        Video Speaker (33:33):   First, the platform uses the same credentials as **my.ncqa.org**. You can go
456   directly to **digitalcommunity.ncqa.org** starting July 22, or through **my.ncqa.org**, if you already have an NCQA account. Once you're logged in, browse existing
458   content and respond to posts where you have a perspective to share. If you have a question on NCQA or need some feedback from others, start posting. To
460   create a new topic, go here. Another way to navigate is to use the search box here. If you have any questions on the platform, email us at
462   digital.measures@ncqa.org, or better yet, ask in the platform.

        Video Speaker (34:14):   Meet us at **digitalcommunity.ncqa.org** and let's build a collaborating
464   community on digital measurement.

        Michael Barr (34:21):   Well, hope you liked that video. I've seen it a couple of times now and I notice
466   something new every time I look at it. Again, this website will be live at the Digital Quality Summit and if you would like to sign up for free, you can see the
468   information on this slide, and if you want to re-tour, please look at the Bitly—you can use that again and show your colleagues. There will be a lot of discussions
470   about many of the topics that we've covered today, including telehealth, so please join the Digital Measurement Community!

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474	Michael Barr (35:00):	All right, we've covered a lot of territory today. We've talked about telehealth and "align, adapt, innovate." This will now be formally part of the future of HEDIS, and one of the things I noticed about the Digital Measurement Community demo was [that] we need to update the slide with the five, now six, topics. I tried to clarify a little bit about measures terminology. Traditional, electronic clinical quality measures and digital quality measures.

We announced unlocked value sets, which we hope will help reduce errors and omissions and certainly cut down on manual labor, in terms of typing in the value sets.

The Digital Quality Summit, July 22 and 23.

The Digital Measurement Community, launching July 22.

The FHIR measures timeline in terms of pilot measures being released later this year and moving to FHIR-CQL in subsequent years, and the schedule change—which a lot of NCQA staff have been working on for quite some time—has finally arrived.

July 1, you'll get Measurement Year volumes for 2020 and 2021.
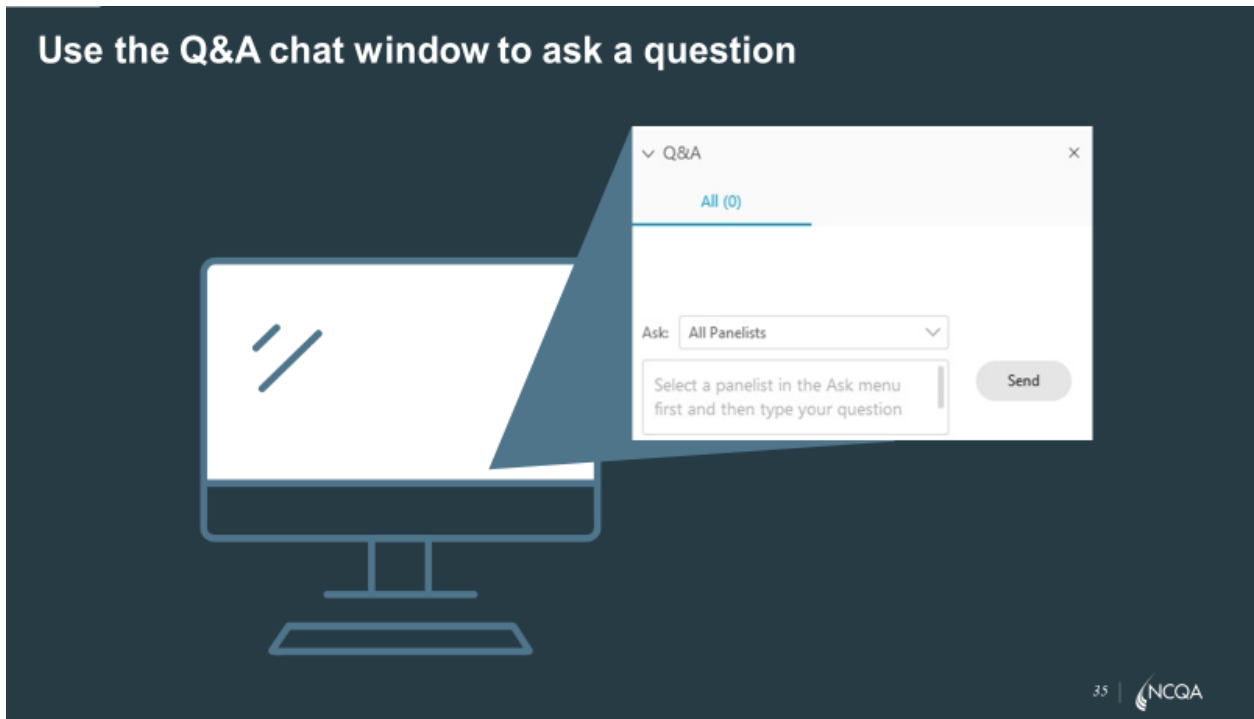
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Michael Barr (36:01):   That covers the content of the Future of HEDIS webinar for today, with the
492   emphasis on telehealth. We're going to take Q&A. I'm going to turn it over to
                             Andy Reynolds. Andy, over to you.

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496	Andy Reynolds (36:12):	Thank you, Michael. Good afternoon, everyone. Thank you for the questions you've submitted and we urge you to continue submitting questions. Many have
498		come in so far, so let's get to them right away.
500		I can dispose of several of them myself. Several people have asked if they will receive the slides. Yes; we will email slides to everyone who has attended today; and in fact, if you go to our homepage right now, ncqa.org, we have posted for
502		you on the homepage, just beneath the picture of the smiling baby, you will see a link: Telehealth and the Future of Quality. Click there to get through the slides
504		that Peggy and Brad and Michael have presented so far.
506	Andy Reynolds (36:51):	Others have asked, "Will we receive a transcript?" The answer there again is yes. If you give us a few days, please, we will transcribe all of today's discussion and post that transcript at that same URL.
508	Andy Reynolds (37:05):	Lots of questions also on FHIR, starting from the very basic: "What does FHIR stand for? Why is it important, and should we conclude from Dr. Barr's earlier
510		slide that FHIR measures will not be available until 2022?" So again, what's FHIR, what's the big deal, and do people have to wait until 2022?
512	Michael Barr (37:27):	Great, I'll take that to start, and Brad, if you have any comments about the technical specs, I'm happy to have you chime in. FHIR stands for "Fast
514		Healthcare Interoperable Resource"—try saying that five times fast. It's an HL7 standard and it allows information to pass much easier than current existing
516		standards and helps with interoperability and so on. It's a data model.
518	Michael Barr (37:51):	We will be pilot testing [and] allowing others to pilot test a handful of HEDIS measures on FHIR using clinical quality language that's consistent between our existing digital measures and those we're going to do in the future, and those will
520		be released probably [in] October, November. So again, they're not intended for use in reporting the HEDIS cycle, partly because of the technical challenges in
522		moving them forward and partly because we want to get the QDM measures right for reporting. We're offsetting the release of the FHIR-CQL measures to the fall
524		and those of you who want to test those, feel free to do so. We welcome your feedback.
526	Michael Barr (38:32):	Our expectation is that the vast majority of the digital measures we release this year in the quality data model, QDM, will be released in FHIR-CQL for use in
528		reporting next July. That would be July—probably August—of 2021. Then from that point forward, digital measures will only be specified in FHIR-CQL and we
530		will continue to build that portfolio over time.
532	Michael Barr (39:03):	Brad, if you want to add anything about FHIR that I messed up, since I'm not the technical person on the call, go ahead.
534	Brad Ryan (39:10):	Thanks, Michael. I certainly don't think you messed anything up, but I will add a little bit and build on something you mentioned. So, digital quality is much more than digital specification of a measure. When Michael says that FHIR is a set of
536		standards, it's a set of standards that bridge across quality measures, and health care data specifications and data standards, and clinical computing in general,
538		for things like care guidelines in a computable format.

540	Brad Ryan (39:48):	When you think about the promises of a conversion to digital for quality, part of that vision of the future is, say, a FHIR-CQL based measure specification, where a specification no longer has to be interpreted by a developer and written into code. It's specified in the code that can be executed, but that's only a piece of the puzzle. When you think more broadly about what FHIR standards in general offer, it let's you reconceive the types of quality measures one can even build; quality measures that leverage more clinical data rather than only administrative data. It allows measures that, therefore, align more closely to best practice guidelines; in fact, it could almost be a complement to something like a best practice guideline or clinical decision support rule where the same data, the same logic, can drive both.
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550	Brad Ryan (40:52):	It allows for better measures; it allows for those measures to be more useful near the point of care delivery, where patients and buyers are engaging with their health care, whether that be at a visit or the telehealth modality. So, it really opens up a world of possibilities that go beyond just streamlining what we already do. It certainly does that. We get a lot of benefits in what we already do with HEDIS, but it unlocks a lot of other use cases and a lot of other value that we're excited to pass on to the users.
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558	Brad Ryan (41:29):	When you talk about the Digital Quality Community, that's a big overlap with some of those other pieces of data collection—best practice guideline development as well as quality measurement—to sort of tie those pieces together and enable us to work on use cases that we haven't been able to get at in our traditional models. So, I'll stop there. If you can't tell, I'm very excited about the prospect here. FHIR is just a way of capturing a lot of common standards [inaudible 00:42:06].
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564	Michael Barr (42:14):	Thanks, Brad. And the other thing I'll add is that as our team has been doing this, one of the challenges is FHIR is evolving standards; so even earlier today, we had a conversation about the challenges of something called the Claims Resource—in other words, attaching FHIR to claims, because as Brad said, it's really meant to be clinical information. The team is working on this and that's part of the reason why we have stayed with QDM this year and we'll move, as I said, to the next iteration of digital measures.
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572	Andy Reynolds (42:48):	Thank you, Michael. It's Andy again. We have several questions about the newly updated 40 HEDIS measures. One is, "Since those 40 measures apply to Measurement Years 2020 and 2021, does that mean that all of the changes will hold until 2022, even if the pandemic ends before 2022?" So again, recent changes to 40 measures. How long are they going to stick around?
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576	Michael Barr (43:18):	Andy, I'm not sure if anybody from NCQA and the Policy shop is on, but my understanding is [that it's] a decision yet to be made.
578	Andy Reynolds (43:28):	Okay. And can you say any more about the changes to those measures? For example, did they include video requirements or allow video in all those measures?
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582	Michael Barr (43:41):	Prior to the update this month, many of the measures already had telehealth incorporated, so the 40 additional changes were made to enhance what's already been there—telehealth… video… and so on.

584   Andy Reynolds (44:22):   What assurances are there from private and public payers that the looser rules and better reimbursement for telehealth will continue after the pandemic? Will
586   payers really continue to pay more for what they used to pay very little for?

    Michael Barr (44:37):   Great question! I was able to listen to a little bit of a Telehealth Task Force
588   session earlier today that I referenced in my comments, and that was one of the key topics they brought up. What should CMS do; what policy changes need to
590   be anchored and kept; and how do they convince CMS and other payers to continue to reimburse where they have [been] during the pandemic. I'm not sure
592   if Peggy is willing, or able, to talk a little bit more about the Telehealth Task Force conversation, but Peggy, if you'd like to make a comment, I'll pause here for a
594   moment.

    Peggy O'Kane (45:15):   The issue's on the table, but certainly we were just introducing [it] ourselves
596   today. I know that CMS has expressed its commitment to continuation of telehealth and I don't think they've committed to whatever the payment models
598   were, but I know that they know if they went back to the old way, that would kill it. I think there may be a more nuanced payment policy that emerges finally, and it'll
600   be different by specialty and so forth, but I really believe what I've heard—and I've heard it from commercial payers, as well—that people believe that there's a
602   lot of promise here and having adequate payment is part of the formula for having it continue.

604   Michael Barr (46:05):   Thank you, Peggy, and one more update from the policy folks. Thank you, Cindy. The HEDIS measure changes include telephonic telehealth, video services and
606   e-visits in the portal and for select measures, as outlined in the release. Andy, back to you.

608   Andy Reynolds (46:21): And Michael, back to you with another question about FHIR. What is the relationship between FHIR measures and ECDS?

610   Michael Barr (46:30):   All right. I'll give it a try. Those of you who have heard me before, I'm not the technical person. ECDS is a reporting method. That's NCQA's way of having
612   data come in on those specific measures that have an ECDS reporting method attached to them, as opposed to the traditional method. All ECDS measures are
614   expressed digitally, currently, and those expressed digitally are using the quality data model and clinical quality language. What we're doing, going forward, is
616   replacing the quality data model with the FHIR model, Fast Healthcare Interoperable Resources. So, I hope that answers the question. Brad, is there
618   anything you want to add to that?

    Brad Ryan (47:11):   This can be a little bit confusing, because FHIR represents a collection of
620   standards. Some of those standards are a way of expressing a measure, such as CQL. Sometimes those standards are a way of talking about data models. That is
622   the case that we were talking about with CQL FHIR measures, meaning that the data model those measures are specified against is a FHIR data model. FHIR
624   can have other standards associated with it, as well. It does have many other standards associated with it.

626   Brad Ryan (47:50):   ECDS is one way of implementing and collecting data on digital measures. That is an NCQA term. FHIR and all of those standards are industry terms. "ECDS" is
628   an NCQA term.

Michael Barr (48:04):   Great. Thanks, Brad.

630   Andy Reynolds (48:09): Another terminology check. With regard to eCQM measures, I thought these
       were governed by CMS. Can you clarify how NCQA is involved in eCQM
632   measures?

Michael Barr (48:20):   Certainly. NCQA does author some ECQMs under contract, sometimes as a
634   subcontractor, for CMS. So many of our authors write measures under that
       contract. Some of them are our measures—like HEDIS measures—that were
636   specified for clinician level, and so that's part of the portfolio we manage. Others
       are part of the contract we have as a subcontractor to CMS.

638   Andy Reynolds (48:56): David Stevens writes in, "I noted that social determinants [inaudible 00:49:00] is
       one of the areas covered at the Summit. Is NCQA developing a vision around
640   health equity issues as part of measurement and improvement including
       telehealth?" So again, social determinants. Is there a plan or vision for health
642   equity issues as part of measurement and improvement, including telehealth?

Michael Barr (49:19):   Peggy, would you like to chime in to start this question?

644   Peggy O'Kane (49:23): We have been working with CMS on some strategies for more clearly identifying
       disparities in care. I think collectively we've been held back by the unavailability
646   of race data, although CMS has it for Medicare. I think that part of our intention is
       to try to see if we can't push towards more common availability of race and
648   ethnicity data.

Peggy O'Kane (50:02): Beyond that, I think we have committed as an organization to understand better
650   what needs to be done and to put whatever muscle we have behind it, or the
       collective muscle with payers that we work with. That still remains to be sorted
652   out. It's not simple, as you're aware, but we believe that we're currently at a very
       unacceptable place in terms of outcomes, and the part that health care plays in
654   that, I think, needs to shape up better. There are also many other contributors to
       that, including economic inequities. We're committed to doing our part and to
656   showcasing organizations in health care that are doing their part. I hope that
       answers your questions.

658   Michael Barr (50:52):   Thank you, Peggy.

Andy Reynolds (50:53): Very simple question. What's going to happen with hybrid measures? Is hybrid
660   going away?

Michael Barr (51:05):   It's a simple question with a complicated answer. I think, in general, the idea of
662   chart abstraction, manual chart abstraction, going to the records—which was
       interrupted, in fact, during this HEDIS cycle because of the pandemic—is
664   probably not a long-term strategy in that we need to look for better ways to
       assess population-level measures. Part of that is through the digital measures
666   we're trying to create, but then you have the challenge from a health plan
       perspective [of] how do I get enough data digitally when there's so many different
668   places for the data?

670	Michael Barr (51:43):	Clearly an evolution needs to take place. We're trying to assess how much of a lift data from chart abstraction or hybrid measures gives to health plans, and perhaps you might see some measures for which that lift has been diminishing over time; in other words, the percentage increase in the measure rate, or the quality measure rate for our hybrid measure, is less and less associated with that chart abstraction. That means that those health plans and others have found other sources of data, supplemental data and other [data], not manual chart abstraction. So, you might see early on, in terms of measures, that the hybrid option is reduced.
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678	Michael Barr (52:23):	We're hoping that as the health system matures and more data are available through interoperability, through the 21st Century Cures Act, which takes away some of the information blocking, the data will be more readily available and we can rely less upon chart abstraction, because it's costly, consumes a lot of time [and is] labor intensive.
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	Michael Barr (52:49):	Peggy, do you want to add anything to that, or do you want to leave it there?
684	Peggy O'Kane (52:53):	We're also committed to having a fair process of measurement and we understand that the data environment plans face is very different. We're trying to honor that and we know, for example, in Medicare Stars, people are interested in every last point that they can get, or a tenth of a point. It's an awkward situation. I think none of us thought we'd be here at this point, and the sooner we can get rid of it without feeling bad about people that have a more challenging data situation, the better.
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	Michael Barr (53:31):	Thank you, Peggy.
692	Andy Reynolds (53:33):	Seema Verma has discussed the need to enter into more value-based care. What is the NCQA position on value-based care in relation to telemedicine or in general?
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	Michael Barr (53:42):	Peggy, do you want to take this one?
696	Peggy O'Kane (53:47):	I think that I, too, share Seema Verma's point of view that health care costs in this country are too high and I think we haven't even begun to reckon with the additional costs of COVID and the survivors of COVID, many of whom are going to have very expensive conditions to take away from that experience. So more than ever—and health care has already been eating up our national resources—I think we need to get to a payment model where if you become more efficient— and let's face it, telemedicine will allow care to become more efficient—you don't lose money. Because when people lose money when they become more efficient, they don't become more efficient, and so in the telemedicine world, I think if you're able to kind of run the crank more easily, it could lead to enhanced costs, and I think that's why people were afraid of it in the first place.
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708	Peggy O'Kane (55:02):	The sooner we get to a situation where health care entities are accountable for cost and quality of care, the better the utilization will be and the more we'll make progress, I believe, using these new technologies to make care more affordable, more patient centered and clinically superior.
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712   Andy Reynolds (55:25): I think we have time for one more brief question. It, too, is rather big. What is NCQA most excited about and most worried about with regard to telehealth?

Michael Barr (55:35): Peggy, I think that's you again.

714   Peggy O'Kane (55:41): Well, I'm most excited that people have gotten off the dime. I'm sorry it took COVID to get there, but I think when you see the panoply of ways of making care
716   more continuous and actually bringing the patient more into the care situation in a much more central role, I think it's amazing. We just approved some measures
718   for cardiac rehab and I know that there is really great work being done with telemedicine cardiac rehab that people do from their homes. I've seen some
720   preliminary data that shows how much the utilization picks up and how much tremendous people get from that. So, I think there are breakthroughs that are
722   waiting to happen when we really get this launched beyond the pilot stage.

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