Please note: This transcript has been lightly edited to facilitate reading spoken statements in writing.
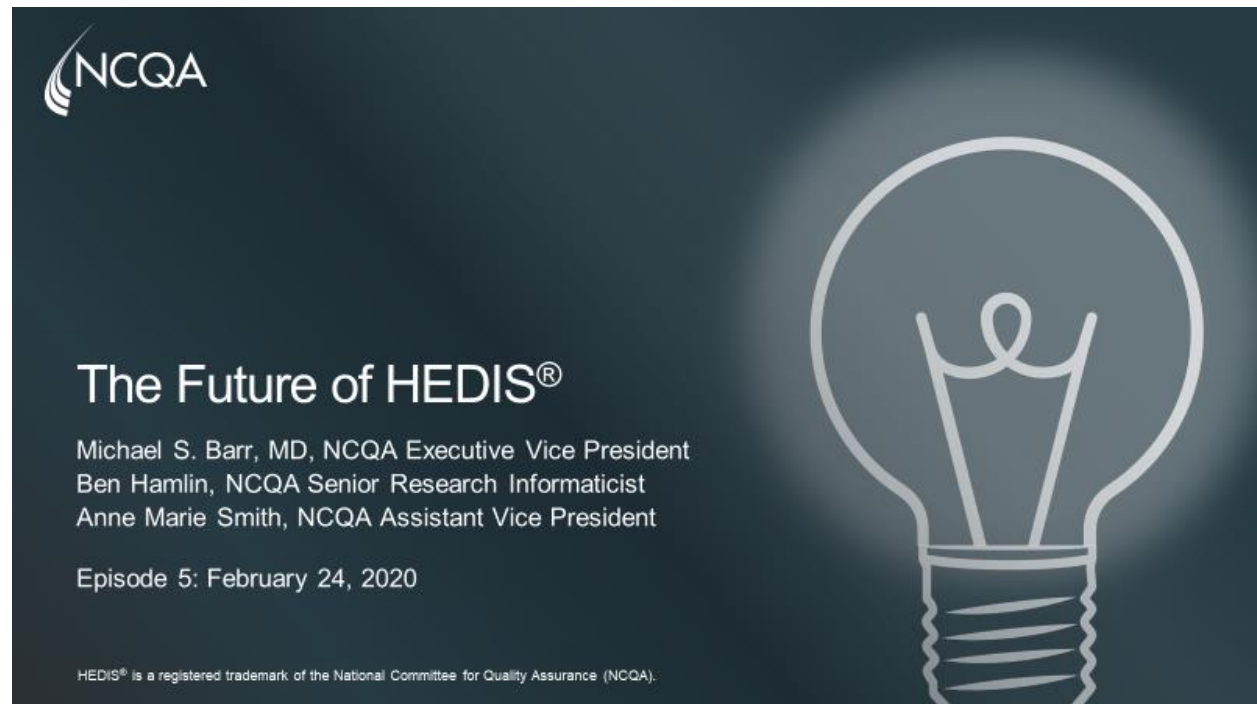
Speakers:
Michael Barr, NCQA EVP, Quality Management and Research Group
Andy Reynolds, NCQA AVP, External Relations
Ben Hamlin, NCQA Lead Performance Scientist
Anne Marie Smith, NCQA Director of Measure Validation

Michael Barr (00:00):

Hello, everybody. This is Michael Barr, Executive Vice President for Quality Measurement and Research at NCQA. Welcome to the fifth webinar in the Future of HEDIS series and the first episode in 2020. Today, I will recap some of 2019's important decisions and announcements about the Future of HEDIS. Then we'll share some of our evolving ideas about 2020. We'll also be asking you to respond to a few questions to help us with our plans.

Michael Barr ([00:16](#)):

Over 9,800 people have registered for all of the webinars in this series that started in July 2019. That makes the Future of HEDIS our most popular webinar series ever.

Michael Barr ([00:39](#)):

We especially want to welcome the many people on today's call who are new to this series. We understand that over 60% of you are learning about these topics for the first time today. Because so many of you are seeing this information for the first time, we will start with a high-level summary of previous webinars. For those of you who attended earlier presentations, we think this will be a helpful reminder, but don't worry, we also have some new information to show you, too.
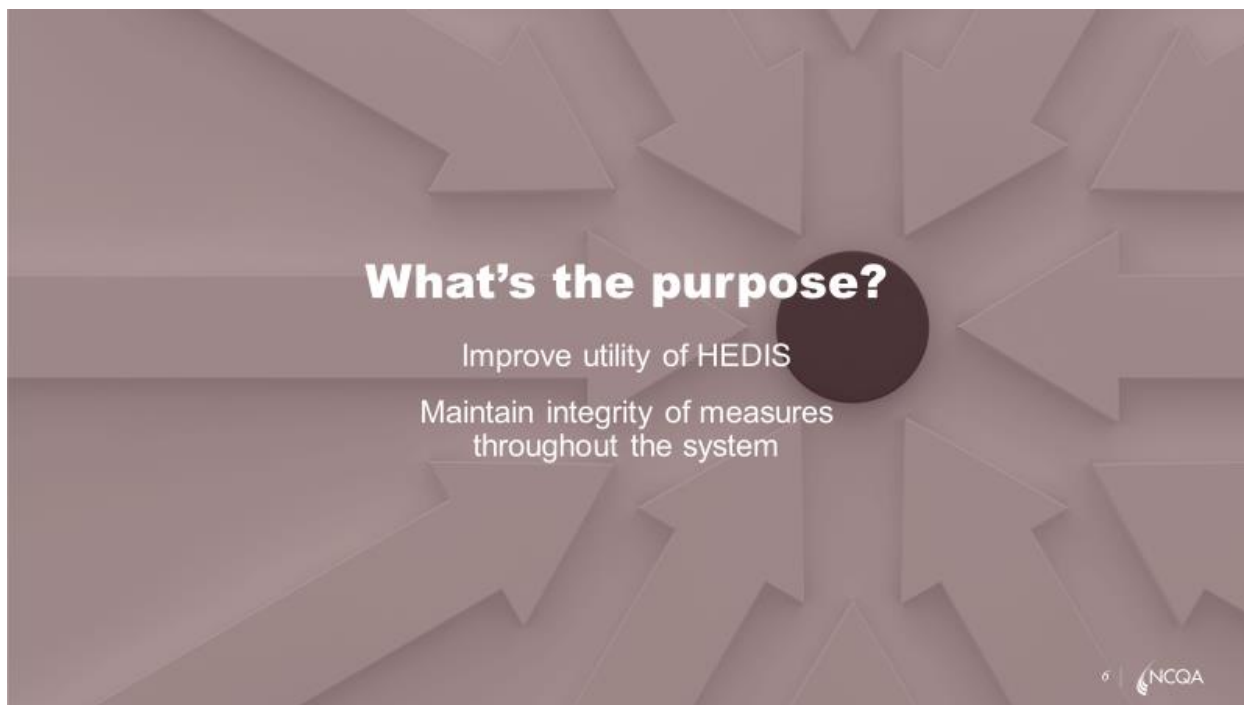

Michael Barr ([01:02](#)):

So, [for] those new to this series, I would highly encourage you to listen to early webinars to get some of the details. I will not cover it in a quick recap of 2019. We will post today's slides as soon as the event ends and we'll post the recording of today's discussion in a few days, followed by a transcript in two weeks.

Michael Barr (01:28):

So, why change HEDIS? Why now? Start with the big question, why HEDIS always evolved over time, but now we're at a point of substantial change in the health care environment. There are more accountable entities, more data will become available to support evolution of measures and our programs.

Feedback from stakeholders and from market research has also shown that [we] need to change in order to improve our ability to measure what matters. Our vision for the future of HEDIS is a system that's fluid enough to support the front lines of care, delivery and evaluation of health plan performance.
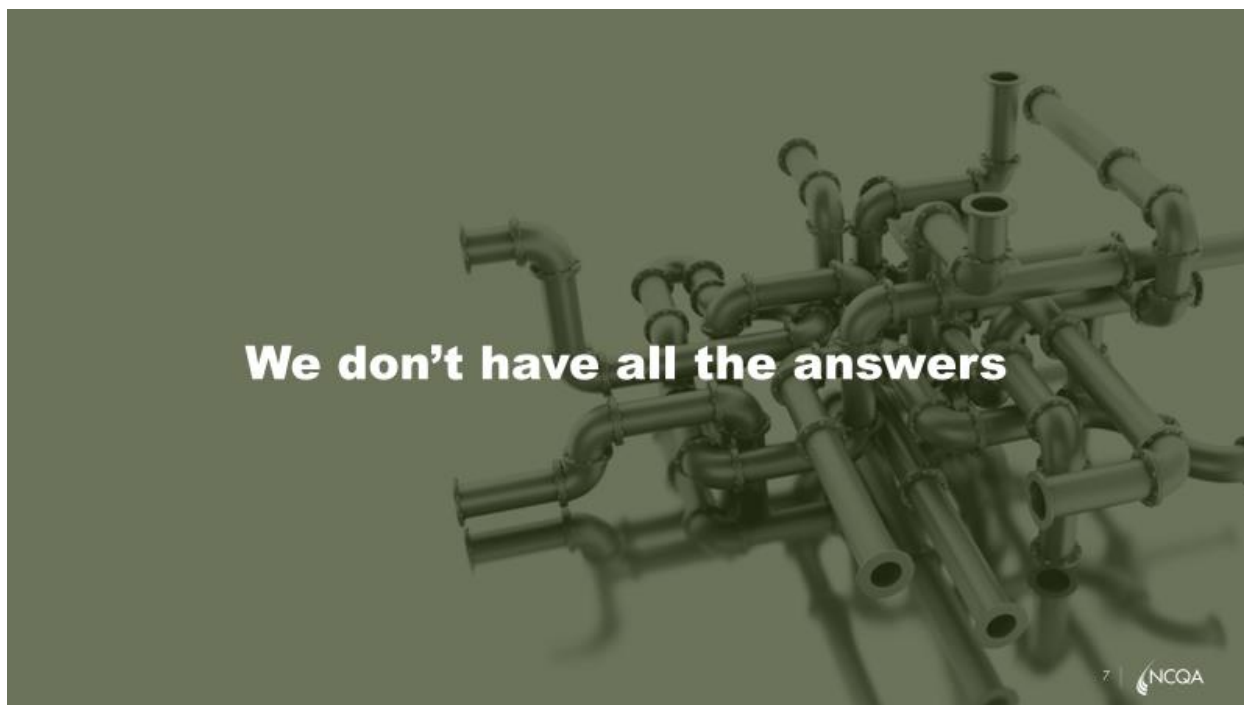
Michael Barr (02:02):

And we see a situation where measurement is a byproduct of good practice and documentation. That's something that requires additional work just for the sake of producing measure results. And in that environment, we think measurement can fuel and inform practice. What's the purpose? At least two purposes come to mind. First is to improve the measure set's utility, and second is to protect the integrity of measures, no matter where they're used. These purposes become important in a value-based environment where people are paid for achieving certain levels of performance.

Michael Barr (02:36):

In the past, we've often had a HEDIS measure that a plan is reporting and the medical delivery systems were doing their own variations of that measure. We're trying to encourage alignment down to delivery system, to avoid the variations of measures, which creates unnecessary work with minimal return on value for all the effort.
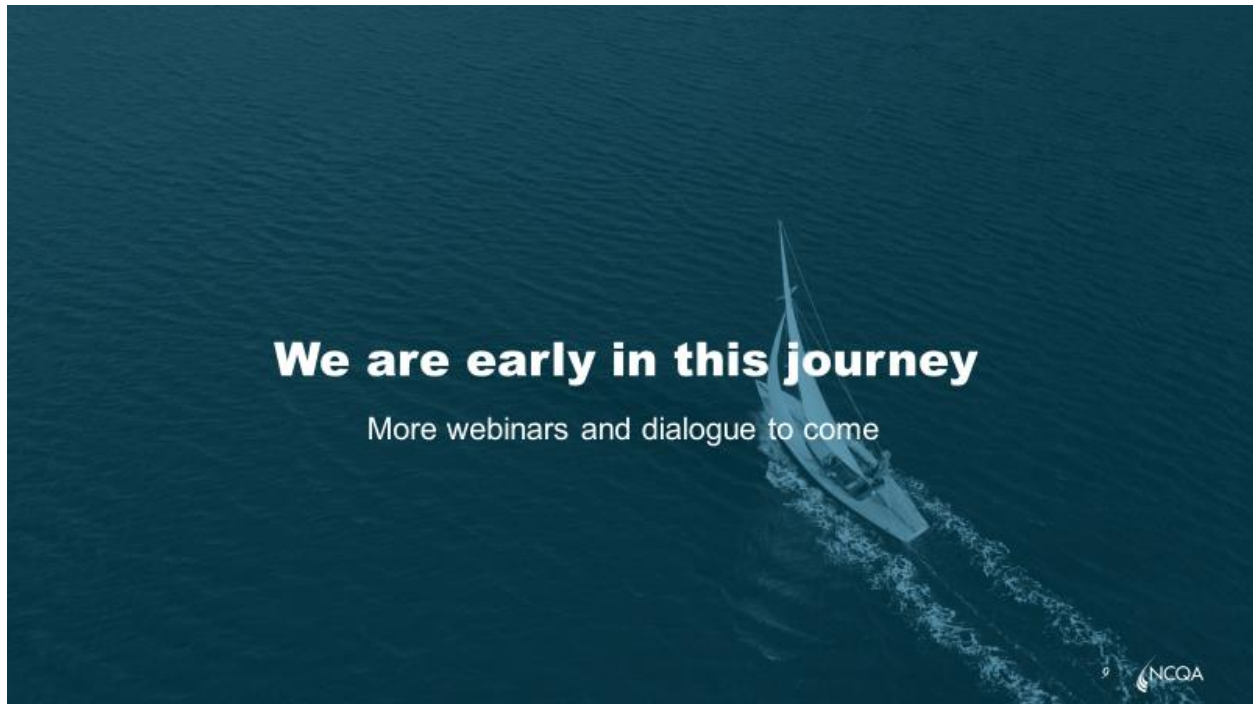
Michael Barr ([02:56]):

Now, let's be clear, we have no illusions that we've figured out everything. We've not. We do have a complex system with a high degree of variability across the country and [a] readiness and willingness to change. However, we are proceeding carefully with input from you and others, and these webinars are efforts to promote the conversation and exchange of ideas. We want to hear from you and we will listen. Today, you'll note, we'll ask you several polling questions later in the presentations, so please be ready.

Michael Barr ([03:26](03:26)):

This is a process, not an all-at-once event. It's not like HEDIS is one thing and completely different two months [or] a year from now. We will count on you to help us calibrate the pace. We know there will be different speeds for different organizations. Today, you'll hear some of our thoughts about FHIR, Fast Healthcare Interoperability Resources.

Michael Barr ([03:48](03:48)):

Among the many people joining this webinar series for the first time, don't worry, the curtain just went up a moment ago. We're a lot closer to the start of the story than the middle or the end. These webinars are an example of the ongoing process, ongoing dialogue, we want to continue to have, so that is preamble. I'm going to recap some of the key themes from the 2019 future of HEDIS webinar series. These are the five key topics we spoke about.

Michael Barr (04:16):

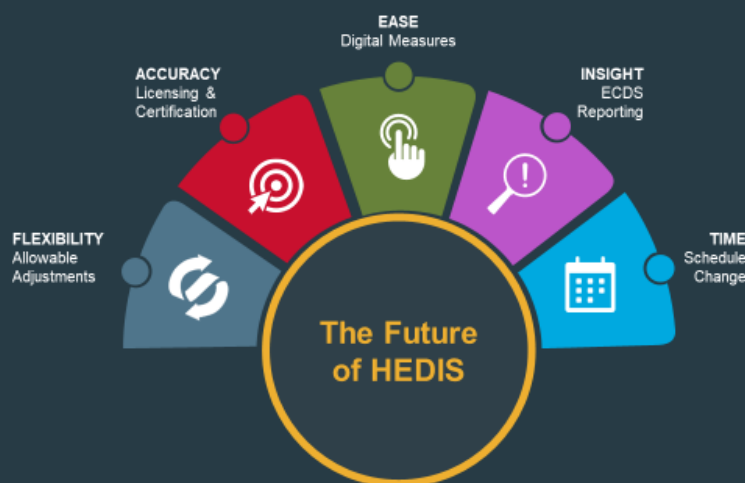Allowable adjustments, licensing and certification, digital measures, electronic clinical data systems reporting and a schedule for change. All five, which we may call the "HEDIS infrastructure" or "how HEDIS works." [It's] not about the content of the measures at this point.

Again, for more detail, please view earlier Future of HEDIS webinars, probably starting with #1 or #2. We went into extensive detail about each one of these topics.

Michael Barr (04:45):

Let's briefly talk about allowable adjustments. This is a new flexibility associated with HEDIS. We introduced allowable adjustments a year ago with HEDIS 2019. 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 guide adjustments to the measures without changing their clinical intention.
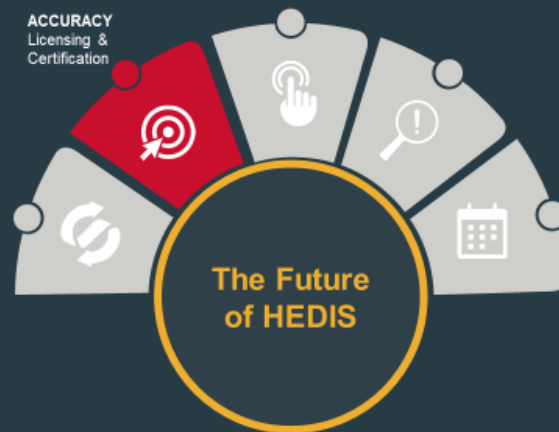
Michael Barr (05:08):

Allowable adjustments also allow you to use HEDIS at different levels of the health care system and for purposes other than health plan reporting. For example, you should be able to filter results by product lines just not off enrollment criteria. We'll focus on a population subset. For example, a narrow age range or particular demographic.

Michael Barr (05:32):

Licensing and certification. At the same time, allowable adjustments expand the uses of HEDIS at different levels of the health care system. We need to ensure that the use of the measures is appropriate and the results produced are accurate, by expanding our licensing and measure certification efforts. 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 when you buy Volume 2 is all you need.

Michael Barr (06:01):

If you are a health plan that uses internal software to report to HEDIS, your plan software must be certified by NCQA, or you must contract with a certified software vendor no later than 2021 for HEDIS reporting in 2022. Any software used to calculate the reported HEDIS measures for rates must have a separate HEDIS license and be certified by NCQA. The point of licensing and certification is to help you ensure HEDIS results are accurate, reliable and can be used for all the purposes you intend—most importantly, improving clinical care.

Michael Barr (06:38):

Digital measures. Well, digital measures help reduce the implementation time, human errors, non-standardization. Right now, I'm talking about digitalized versions of existing HEDIS measures that many plans currently report the traditional way. In a few minutes, I'll talk about measures for electronic clinical data system reporting, which are also digital but reported differently.

Michael Barr (07:00):

In October, NCQA released eight HEDIS 2020 digital measures for traditional reporting. These are machine readable and downloadable from the NCQA store. Digitalization means NCQA writes measures in computer code, so you don't have to. It eases the need for entities to read, interpret and recode measures and that helps avoid human error and non-standardization. Our digital measures follow industry standards, so HEDIS is easier to implement across the continuum of care.

Michael Barr (07:29):

That consistency means providers [are] measuring themselves; we use the same clinical constructs that they do when they report HEDIS results to health plans. So those watching today are more technology oriented, and you'll be interested to know that we currently use the quality data model for reporting them. As mentioned earlier, the subject of today's updates by Ben Hamlin and Anne Smith will be our thoughts about FHIR, Fast Healthcare Interoperability Resources.
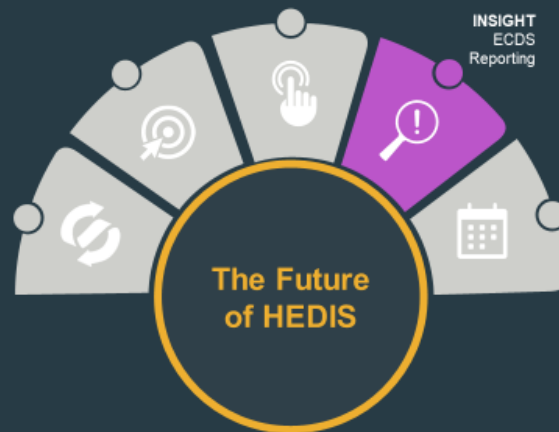
Michael Barr (07:56):

Electronic clinical data systems reporting helps generate new insights about quality from data generated from HEDIS. These are subset of the NCQA digital measure portfolio. All electronic clinical data systems measures are digital, and not all digital measures use the ECDS reporting methodology. ECDS data are reported in four categories according to their source: electronic health records, registries or health information exchanges, management systems and administrator files.

Michael Barr (08:29):

ECDS reporting brings all of the efficiencies of the digital measures I spoke about just a minute ago and reorients quality measurement toward electronic clinical data from many sources. We invite you to use the 11 digital measures for ECDS reporting currently at NCQA store. Among those 11 are 3 existing HEDIS measures which we added for the ECDS reporting option: Breast Cancer Screening, Colorectal Cancer Screening, Follow-Up Care for Children Prescribed ADHD Medication. We are particularly interested in having health plans report these measures via both traditional and ECDS methodologies to help inform our ECDS strategy.
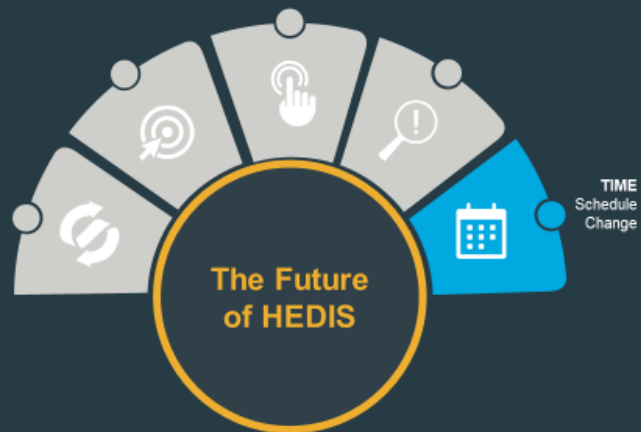
Michael Barr (09:12):

The last topic is a schedule change, to give you access to HEDIS specifications much earlier in the cycle. Our traditional schedule is to release the measures, specs and HEDIS halfway through the current measurement year. For example, the measures released in July 2019 apply to services this entire calendar year, January 1st to December 31st of 2019. That means that the measurement year is half over before plans know what they're expected to report. This 6-month lag has been a feature of the HEDIS cycle for years. Do you think we can do better?
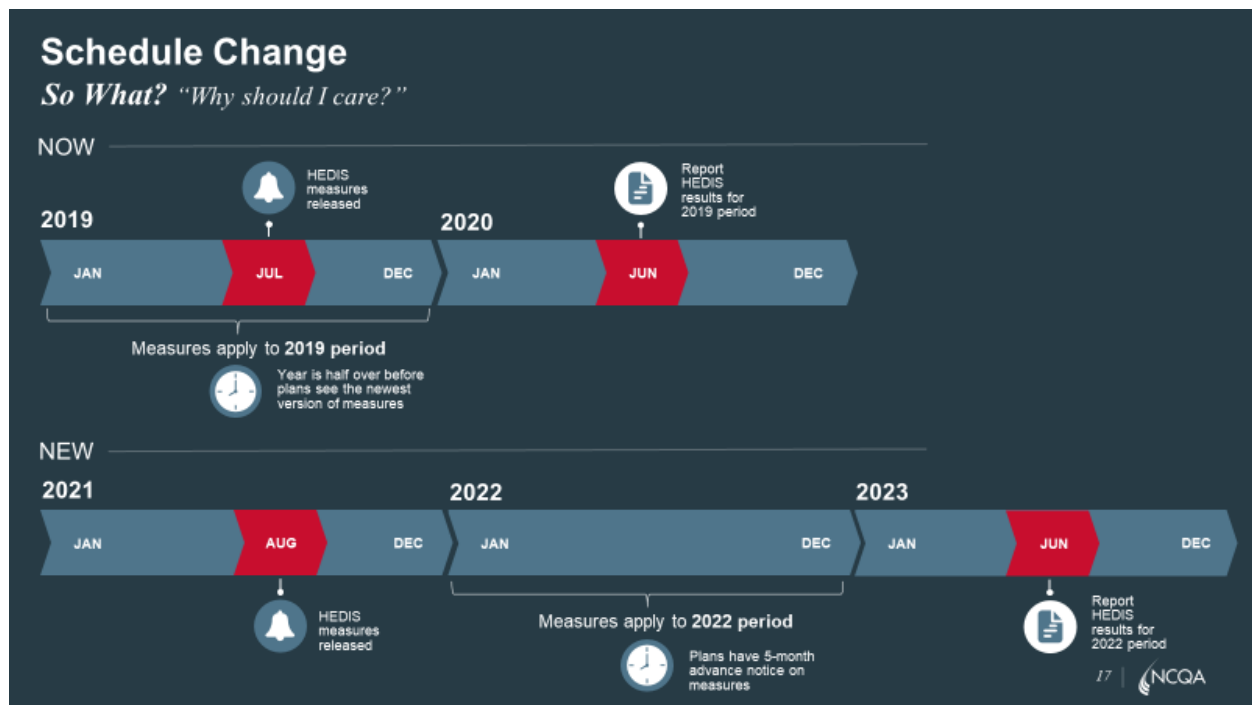
Michael Barr ([09:56](#)):

I'll explain the new way. If you look at the bottom row, you'll see on August 1, 2021, there will be some measures, but these measures will apply to services in 2022. Health plans will have a 5-month lead time. What measures would be in that year? Note that we're not changing HEDIS submission deadlines, which remain in June. Reporting the data will still happen in June of the year after measurement, same as it always has.
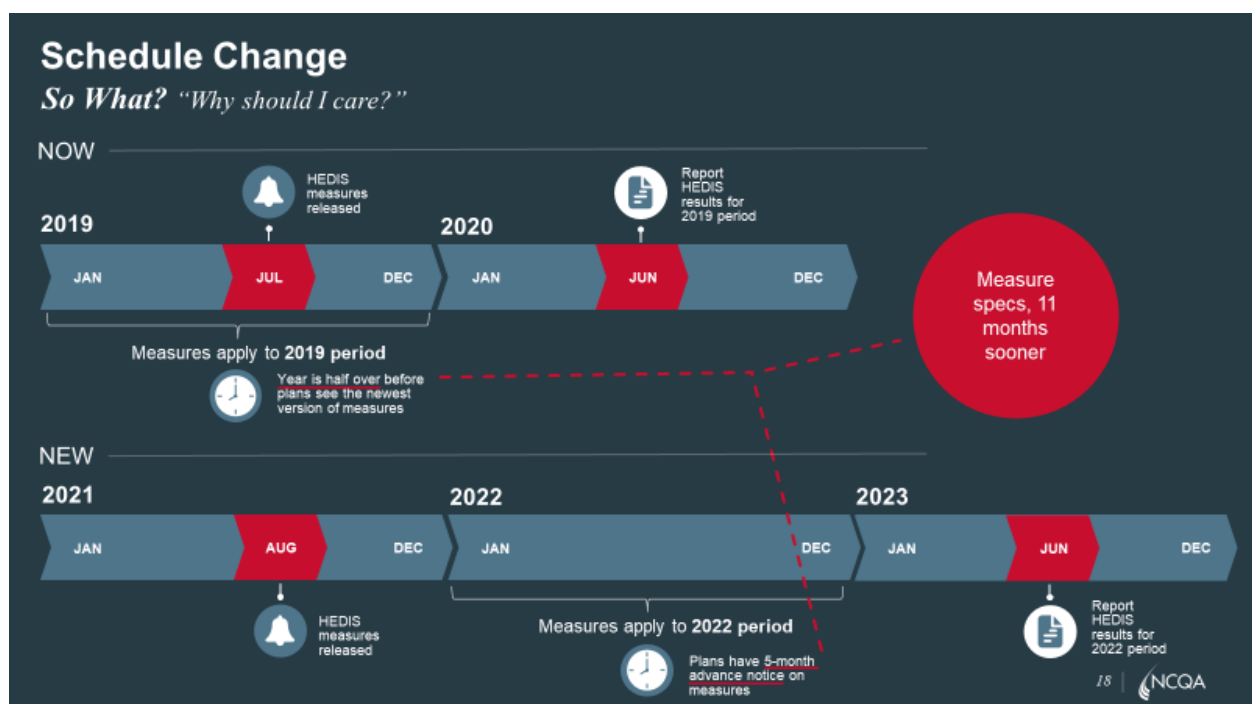
Michael Barr ([10:25](#)):

This shift in a schedule will bring you certainty about measure specs sooner—11 months sooner—and we know that will help you get ready for HEDIS every season. We're also looking for ways to simplify the naming convention. So, let me tell you what we're doing.

Michael Barr ([10:50](#)):

Starting in calendar year 2020, the HEDIS Volume will be named under the measurement year. This table show us how various parts of the annual HEDIS cycle evolve. A lot of information on the slide we know will appeal to those of you who are auditors and have specific roles in the HEDIS process. So please take a look at this slide when you download them from the website. But the most important information is in the red circle. On July 1, 2020, we will publish measures that will apply to measurement years 2020 and 2021. This is the transition.

Michael Barr ([11:28](#)):

So with that quick recap, again, I encourage those of you who want more details to go to the NCQA website and look at earlier webinars. At this point, I want to turn it over to Ben Hamlin, who's going to start talking about FHIR.

Ben Hamlin ([11:45](#)):

Thank you, Michael. So, I want to start by saying you've probably heard a lot about FHIR from a lot of different places, and that is because FHIR has the potential to do a lot of things. My talk today is going to be focused on the use of FHIR for quality measurement, so I just wanted to be very clear on that, when we are talking about what we're using FHIR for and what pieces of FHIR we're using.

What is FHIR®?
Latest interoperability standard

Fast Healthcare Interoperability Resources (FHIR)

HL7 standard

Enables automated data exchange through APIs

Developer friendly

Web-based technology

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Ben Hamlin (12:15):

So, what is FHIR? As Michael said, it stands for Fast Healthcare Interoperability Resource. It is a standard that was developed by HL7 International, which is a standards development organization. The standard was developed to address this idea of health care interoperability on an international scale. Not just the U.S. health care base, but it's an international standard for exchange of health care information between entities that need to use this information. As I mentioned, it's an HL7 International standards, so this is the standard organization that is in charge of FHIR standards development and the new aspects of the standard.

Ben Hamlin (12:57):

The key difference between FHIR and prior standards is this idea that the data exchange essentially happens through current technology. So this idea that things are moving towards the cloud, web-based, API based information. FHIR really takes advantage of that, and so not only standardizing the definitions and the metadata elements around these definitions, but in such a way that it can easily be shared across entities through the internet.

Ben Hamlin (13:32):

When we say, "developer friendly," it's a very understandable standard you use in terms of the specifications, as well as the principles for using it, and it's a specific-use case. It's not an extremely obscure and complex standard; it's very applied. I call it "approachable."

So now we're going to start with our first polling questions of the day. We would like to ask everyone to take our real-time survey to let us know your current level of FHIR understanding. And I will sit here and sing the jeopardy theme while you're doing this poll, so we can see what this audience knows about FHIR and where they are in terms of their FHIR implementation… or not.

Ben Hamlin (14:15):

Please check the side of your screen to let us know where you stand. Okay. It's looking like the results here indicate that most of you are not that familiar with FHIR. That is okay. Again, it's an emerging standard, it's a newer standard. It's also a very approachable standard.

Why FHIR?
Paradigm shift in Health IT

PAST	FUTURE...
Desktop PCs	Mobile devices
Static software	Web-based applications and apps
Organizational records	Longitudinal health record
On-premise server	Cloud
Monolithic data silos	Open APIs
Static reports	Flexible analytics featuring big data and machine learning/AI

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Ben Hamlin (15:04):

One of the reasons we're using it for this is because we are really interested in what it could do for the quality measurement domain. And we'll get into that a little bit more as I go forward. So, again, what is going on here? Well, this slide lays it out for you—we want to meet our stakeholders where they are. And as many of you are aware, much of data is moving into cloud-based or web based applications, as opposed to being locked away on static servers, or it has a much more physical location that's either close to the data user or it's relatively accessible only by the data user.

Ben Hamlin (15:45):

We want to stick with standards that help us look to open APIs and again, enable this exchange of information between health care entities, because we all know that you see several doctors, you receive care in multiple locations, and they should be able to exchange your information whether they're the same company, the same health care system or not. And it really should be this idea that did really go around.

Ben Hamlin (16:10):

If you think about our mobile technologies and what we do, what we use those for and how we use those, health care is a little bit behind that curve. But again, we're really trying to use this FHIR standard to meet everyone where they are and meet the technology where it is and where the world's going. And so, our move to the standard is part of that alignment and that strategy.

Why FHIR for Quality Data?
More comprehensive data model

CURRENT HEDIS Structure

FUTURE HEDIS Structure

HQMF (Metadata, Population Structure)

CQL (Expression Logic)

QDM (Data Model)

FHIR Measure Measure Report (MetaMeasuredata, Population Structure)

CQL (Expression Logic)

FHIR R4 (Data Model)

Definitions:
HQMF   Health Quality Measure Format
CQL   Clinical Quality Language
QDM   Quality Data Model

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Ben Hamlin ([16:31](16:31)):

This is a very basic description of how we construct our quality measures. We use two different components that are key to the measure specification. The first is the data model and the second is the logic model. The data model or those data definitions and those data attributes that define the specific elements of the health care data that we're looking at. For example, a diagnosis of something would be a data element. Diagnosis, depression would be a data element, an encounter would be a data element.

Ben Hamlin ([17:02](17:02)):

Specifically, coded concepts that are available have specific attributes to them. So, medication prescribed versus medication dispensed. And these things are important to the quality measures. And so, we want to use the very standard data model to define these things. The CQL is the expression logic. The expression logic is what ties these different data elements together and creates our measure algorithm.

Ben Hamlin ([17:24](17:24)):

A CQL is a flexible expression logic model. It allows us to do very complicated measure calculations and other things, mathematical equations, which prior logic models did not do. And so now we had this opportunity to develop meaningful measures that everyone is looking forward to in the future. And on the metadata population structure side, that's really just one of the definitions for how the measures export it to the measure construct, the measure format, numerator or denominator, so on and so forth, like the frame of the measure that's built around these QDM and CQL logic.

Ben Hamlin ([18:00](18:00)):

In the current state, we're using a QDM, CQM model. We tried to align our logic and our data model with that for CMS measures, to help with adoption, but also help incentivize this idea that

the measures really could speak the same language. Moving to the future, we are changing our data model to a FHIR data model. We're keeping the CQL—the logic model works very well for us.

Ben Hamlin (18:28):

However, the FHIR data model, again, has many more opportunities for us to develop new insights for using the data. And it allows us to start developing measures that are much more complex, but also much more person-specific and meaningful to us. And so again, we're going to be just changing the data aspect of the model for now. And also sometime in the future, we may consider the FHIR measure report.

Ben Hamlin (18:51):

The FHIR measure report is another sort of standard construct for the measure metadata-to-measure-population piece, the structure of that measure. And again, that's an evolving standard we may actually align with as well, because having the measures standardized in these formats really does facilitate adoption.
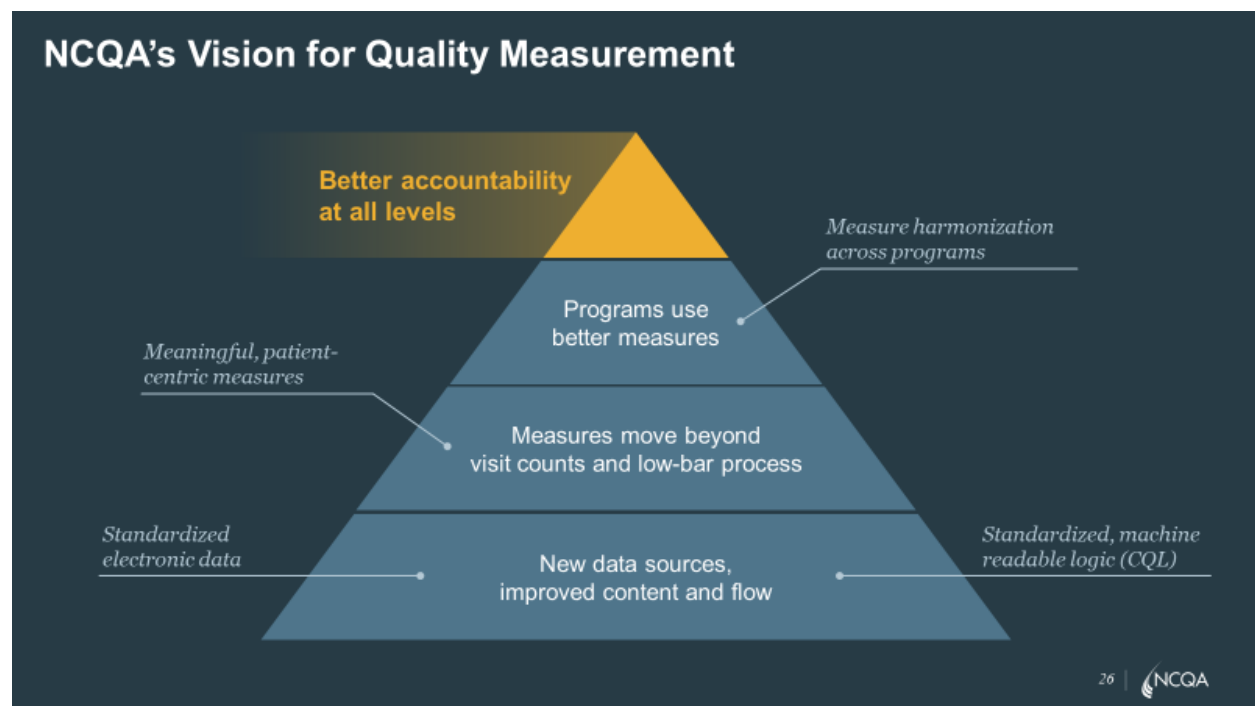
Ben Hamlin (19:09):

So, how are we hoping to get this, and where does this all fit into our long-term strategy for improving quality measurement overall? When we're talking about FHIR and digital quality measures—really at the bottom level of this pyramid here—what we're trying to do is leverage this fact that there's a lot of data out there that could be used for quality measurement and for quality improvement activities. But the existing measure specifications just don't have the definitive definitions, or the specific definitions aren't able to utilize that data effectively and efficiently.

Ben Hamlin (19:38):

Now that we have these digital quality measures, we have the opportunity to develop new measures or modify existing measures to take advantage of this data. And the standard logic model and the standard data models really support this. And so, moving forward in the future, we are starting to see new measures being developed that are more patient-specific and are looking at very unique circumstances for each individual patient.

Ben Hamlin (20:04):

Even though we're measuring at the population level, where we have the technology to do that now, which is fantastic for those of us in quality measurement, the results of these new measures being developed will allow these programs to get to this idea of better accountability and better responsibility. The information flow formerly required a lot of human labor and a lot of other information.

Ben Hamlin (20:28):

Now, a lot of this could be automated. A lot of the data that previously could not be used for quality measurement or quality improvement activities, now it's suddenly accessible and it's very informative and very helpful in creating these pictures, these health care identities of patients who either need care or don't need care. And we have very sophisticated ways to find out now, which we have not had in the past.
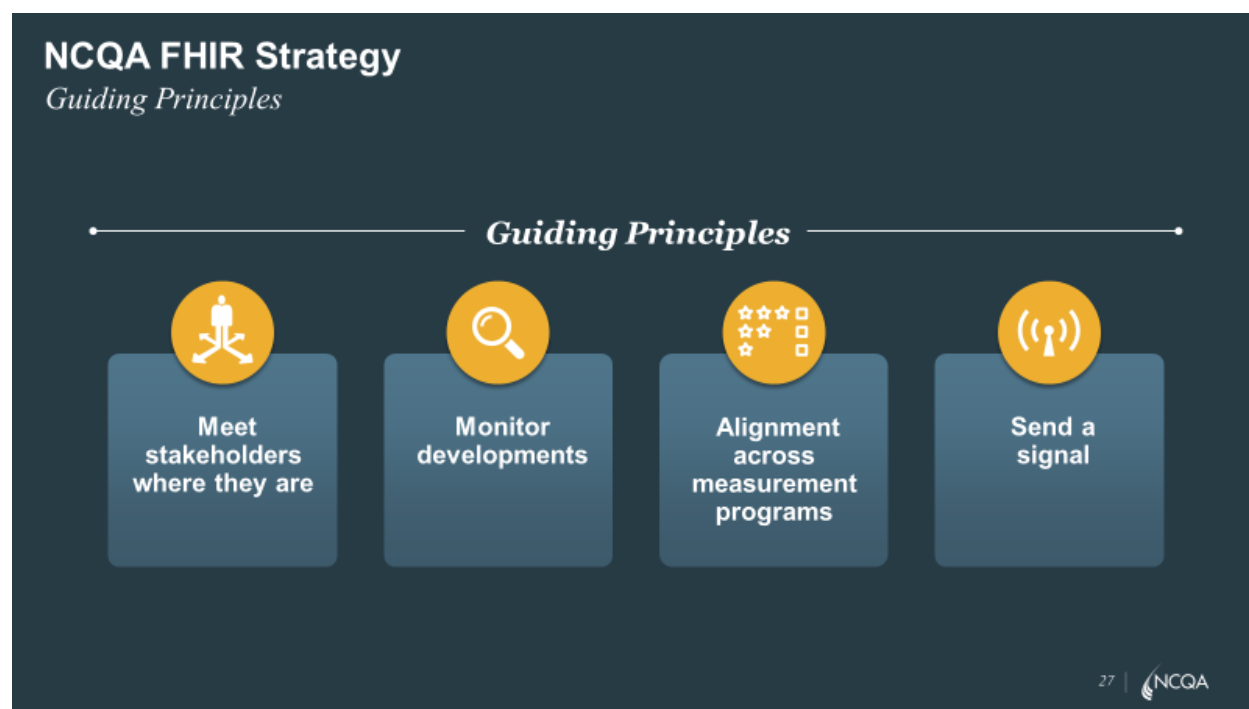
Ben Hamlin (20:51):

As part of our strategy, as Michael said, this is a journey. We're trying to do this in a reasonable time frame that allows us to understand where people are and what they're doing. We don't want to get ahead of our stakeholder community, and HEDIS is a huge program. The measures are used across a number of different programs, as well. And so again, we don't want to get to a place where we're developing measures [that] just can't be used because they're not ready to be used.

Ben Hamlin ([21:17](#)):

There are also different levels of readiness for this technology. And so again, we want to make sure that we don't have to wait until every single organization [is ready]. A person can do this, but we have to make sure that a good majority of them can do it and the rest of them are going to be able to do it soon.

Ben Hamlin ([21:35](#)):

We've been monitoring developments. There's open a lot of work regionally coming out; the federal policy rules from the Austin National Coordinator for Health Information Technology. In terms of the 21st century Cures Act, the information blocking that came out of that Act was a useful stimulus for freeing up some information that [can] be then used for quality purposes and for health care improvement purposes.

Ben Hamlin ([22:02](#)):

Again, as we did with our QDM, CQL model, the FHIR CQL model we anticipate will be what measurement programs will be using for their measure specifications. We're trying to stick with our co-measure developer friends, but also those in other domains, such as research and clinical care, and other areas, such as clinical trials, where having a standard way of data elements and sharing this information will be useful even in that setting.

Ben Hamlin ([22:34](#)):

And finally, again, we're giving these presentations and we're starting to produce these types of measures to send a signal, but this is where we're going. We understand that you all have a very long lead time necessary to help build your business models, as well as the technology to support this kind of measure use, if you will. And so, we're really trying to figure out ways that we can [do] early notification and also very intense stakeholder engagement along the way, to help everyone get back to the first point, but also help them along in this path as we go together. And with that, I will turn it over to Ann to continue the conversation.

Anne Marie Smith (23:14):

I'm going to talk a little bit about our plan to move to FHIR. And as I do that, you'll also notice there'll be some polling questions coming through. But first, why are we talking about making this move now? One of the reasons—if you think back to Michael's presentation—one of the things that we want to do is help reduce the burden of data collection for physicians.

Anne Marie Smith (23:37):

Physicians' primary purpose should not be to collect data for quality measurement, it should be to take care of patients. And we want to be able to ensure that physicians have the time to do that and that the data we are using is a byproduct of their data collection. We also want to ensure that quality measurement is aligned with clinical decision support. We've heard from physicians that sometimes they feel that their clinical decision support is telling them to do one thing and their quality measurement is telling them to [do another] ... they're being measured against quality that is slightly different than their clinical decision support.

Anne Marie Smith (24:22):

We want to make sure that the clinical decision support and the quality measurement are talking the same language, looking at the same elements and giving the same advice. So, keeping in mind the strategy that Ben has outlined, we are proposing to produce some FHIRs, CQL measures for measurement year 2022 reporting. We would like to start with a limited trial set of measures this year.

Delay in Public Reporting
Reporting FHIR-CQL measures starting in 2023

2020 2021 2022 **2023** 2024

NCQA will delay FHIR-CQL measures reporting until June 2023 (*Measurement Year 2022*) to ensure a sufficient time period to test and implement FHIR-CQL measures

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Anne Marie Smith ([24:50](#)):

What does that look like? And why measurement year 2022? As you think back to the timeline change in Michael's presentation, we know that this July, NCQA will be posting technical specifications that will cover measurement year 2020 and measurement year 2021 reporting. If we try to do FHIR CQL measures this year, that would only leave plans and vendors a couple months to prepare for reporting using the FHIR CQL measures.

Anne Marie Smith ([25:25](#)):

When we publish the technical specifications in August 2021, those specifications will be for measurement year 2022 and reporting in 2023. So, remember, we're moving to publishing the specifications before the measurement year. By delaying the FHIR CQL measures until next year, this strategy gives health plans and vendors adequate time to plan how they will use the FHIR CQL measure packages.

Anne Marie Smith ([25:56](#)):

And that brings us to our second poll. Do you support the current proposal to release the first set of FHIR CQL HEDIS measures for measurement year 2022 for reporting in June 2023? And our categories are strongly oppose, somewhat oppose, neutral—or you could be somewhat in favor or strongly in favor. And of course, there's some people who may not be sure yet. And so, you can feel free to mark that one as well.

Anne Marie Smith ([26:34](#)):

When we did this pre-poll last week, we had actually a similar amount of people who were new to FHIR, who said that they really didn't know what FHIR was and they hadn't used it. And it was interesting because they were split between being in favor of [and] being opposed to this. Some people weren't sure about something so new, maybe. But just this audience, as you can see, is bordering on strongly in favor and somewhat in favor, with some people still being neutral.

Trial Use of FHIR Measures
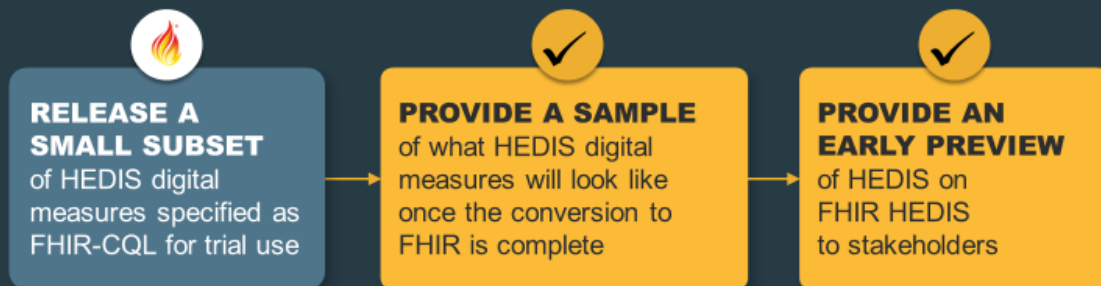
| RELEASE A SMALL SUBSET of HEDIS digital measures specified as FHIR-CQL for trial use | PROVIDE A SAMPLE of what HEDIS digital measures will look like once the conversion to FHIR is complete | PROVIDE AN EARLY PREVIEW of HEDIS on FHIR HEDIS to stakeholders |

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Anne Marie Smith ([27:18](#)):

All right, so what do we have to release? We're talking about releasing a trial use, a small subset of FHIR CQL measures, later this year. And we have two primary reasons for doing that. First of all, we want to provide a sample. We want people to be able to see what the HEDIS digital measures will look like once they're converted to FHIR. We want them to have an early preview so that you can take those measures and look at them and see how they fit into your business plans and how you could potentially use them in your system as you're producing your HEDIS measures.

Anne Marie Smith ([27:57](#)):

We would pick some measures that are in QDM, CQL now to release CQL in FHIR CQL, so you can see some of the differences between the FHIR version of the measure and the QDM version of the measure, to help you understand the measures and the change we're looking at, a little better. And we would also maybe transform, so new measures that have not been in QDM CQL before [would go] straight to FHIR, so you would get a chance to review those and see what they would look like, as well.

Anne Marie Smith (28:31):

And that brings us to our third polling question. What do you think about NCQA's plan to release FHIR measures for trial use in 2020? Are you not at all interested in these measures? Do you have a slight interest in these measures and want to see what they look like? Are you moderately interested in the measures, or are you very interested in the measures? Or are you extremely interested in the measures and wish we have put them out this year already? Or maybe you don't do your own coding; you use a vendor and so you feel that these measures are maybe not applicable to you because it doesn't matter how they get them, but I'm thinking that your vendor will take care of that for you.

Anne Marie Smith (29:18):

Last week we had an audience very similar in composition, and they were "moderately to very interested" in the FHIR measures. I think people were curious to see what was coming out. And this audience is very similar. They are "very interested" or "moderately interested" in taking a look at these FHIR measures and seeing how they could fit into your plans.

NCQA Organizing FHIR Pilots

NCQA will begin FHIR pilots in 2020

We Want Your Feedback!

NCQA will be organizing FHIR pilots starting later this year and looking for volunteers to:

ASSESS
the readiness of the market for FHIR-CQL measures

IDENTIFY
any gaps or issues in FHIR-CQL measure specifications

IDENTIFY
necessary resources to implement FHIR-CQL measures

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Anne Marie Smith (29:54):

All right. What else are we doing? Well, we do want people to be prepared for these FHIR measures, and we want people to understand what it means to have them in FHIR, how it might help them in their business. So, one of the things we're doing is looking to get information. We want to get some pilot information from anybody who is willing to help us. We want to assess market readiness. We want to understand if our stakeholders are ready to adopt FHIR measures and implement them. That's one of the things that we're looking for.

Anne Marie Smith (30:30):

We also want to identify gaps or issues with the FHIR CQL measure specifications or with FHIR itself. We know that FHIR is an evolving standard; it's a fairly new standard. And we moved some of our measures, or looked at moving some of our measures, into the FHIR standard, that we're going to find places where we maybe need to build out the standard a little farther and make it more robust. This is one of the reasons why we want to continue to work with the HL7 organization, so that we can make sure that the standard does cover the information that we need for quality measures.

Anne Marie Smith (31:10):

We also want to identify the necessary resources that our stakeholders need to implement FHIR CQL measures. We want to go on the journey with you and make sure that we know what you need, and you know what we need to be able to produce these and use these FHIR measures together.

Polling Question #4
Would you be interested in participating in an NCQA HEDIS FHIR pilot?

Take our real-time survey

FEEDBACK

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Anne Marie Smith (31:30):

And that brings us to another poll. Would you be interested in participating in [an] NCQA HEDIS FHIR pilot? Are you very interested and want to sign up for [it] right now, today? Are you maybe a little bit interested but maybe you're not the decision maker in your organization? You need to maybe talk it around and get back to us? Are you undecided? Are you unclear where you fit in this FHIR structure? Or are you tapped out and you probably can't participate at this time or your resources are way too limited and there's just not going to be any way you can participate?

Anne Marie Smith (32:14):

Or are you maybe unsure how your organization wants to move forward with FHIR and the HEDIS measures so you're not sure that you want to participate at all? And so maybe this is not applicable. And this one came up too again last week. We had people who were probably a little bit interested, wanted to see how it was going to work out a little bit more to the undecided with this group, or potentially not applicable. And it may be that you're using a vendor to produce your HEDIS measures and you feel that they are the ones who should be participating in the FHIR pilots.

Anne Marie Smith (32:59):

I want to talk a little bit about how we've chosen our measures for digitalization. So, we've already digitalized 19 measures. Those packages are out there in QDM CQL, and we are looking to digitalize some more within the FHIR domain. You will see that we are basing this on feedback we're receiving from various stakeholders [and] we're getting information through these WebEx's. We're also getting information through our policy clarification system, PCS. If you haven't used that on My NCQA, that's a good way to get information back to us, as well.

Anne Marie Smith (33:41):

We also have several conferences throughout the year where we work directly with stakeholders who are using digital measure packages, and they have given us feedback. So, we have quite a few ways that we're getting stakeholder feedback, trying to determine which traditional measures should be converted to digital measures.

Anne Marie Smith (34:01):

We are also looking across our quality measurement programs and prioritizing measures that are not just in HEDIS, but that are also used in other quality measure programs because we do want to reduce the overall burden of the stakeholders, including health plans, vendors and providers. Using measures that are in multiple programs allows you to program once and use that measure across different reporting programs.

Anne Marie Smith (34:30):

We also want to look at the feasibility. We want to ensure that any traditional measures are successfully converted to digital measures—including all measure specifications—before releasing them. So, we want to make sure that all the data elements are there and we can successfully convert the measure before we release it.

Polling Question #5
What are your priorities for digitalized measures?
Take our real-time survey

FEEDBACK

36 | NCQA

Anne Marie Smith (34:53):

I'm sure you all have favorite HEDIS measures. I know that I have my list of favorite HEDIS measures, as well. And so we want to find out from you, what are your priorities for digitalizing HEDIS measures? Are you most interested in the prevention and screening measures, things like breast cancer screening or colorectal cancer screening? Are you interested in the respiratory conditions, things like asthma or cardiovascular conditions?

Anne Marie Smith (35:23):

Is this where you do most of your measurement and you would like to see the measures converted? Maybe it's diabetes or the musculoskeletal conditions, things like rheumatoid arthritis. There are the behavioral health measures, including things like follow-up after mental illness, a hospitalization or ED visit for mental illness, [and] we have the medication management and care coordination measures…

Anne Marie Smith (35:52):

… things like, are you getting the right tests if you're on certain medications? Is overused inappropriateness where your interest lies? Are you using antibiotics appropriately for things like bronchitis, pharyngitis, upper respiratory infection, or do you have no preference for which measures we convert or which order we convert them in?

Anne Marie Smith (36:22):

And I will tell you, because I think the survey's coming up here in a second, but last week, it was definitely the prevention and screening measures that were the most important. And again, this group has said the prevention and screening measures, with diabetes coming in second. And with that, I will turn it back over to you.
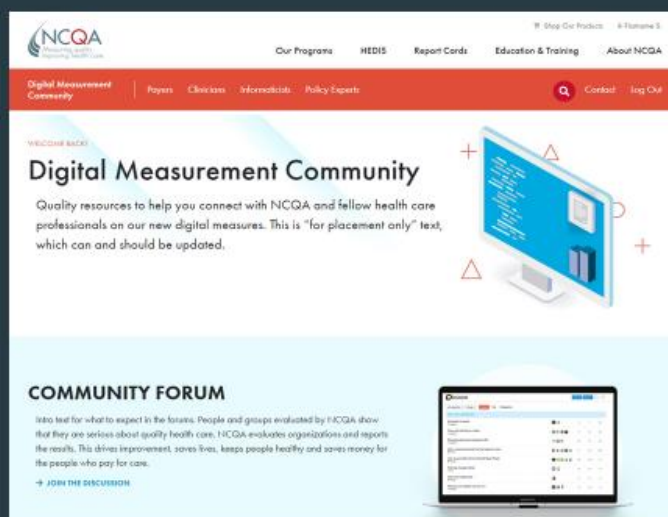
Ben Hamlin ([36:44](#)):

Okay, thanks again. So, you might be asking yourself, how are we planning on doing all this? How do I get involved? How do I interact with the community and understand what's going on? Well, we are going to be launching a new interactive platform that's to be hosted by NCQA, but it's really going to be fed by the community itself.

Ben Hamlin ([37:07](#)):

What we're going to be doing is creating an environment where various stakeholders [come] from across the board. Really, you don't have to be a FHIR expert to be part of the community, or you don't have to be a measurement expert to be part of the community. But [this is] a way that we will be able to facilitate conversations, share best practices, ask questions.

Ben Hamlin ([37:26](#)):

One of the big things that you've heard both Anne and I say during this conversation was [through] a lot of this transformation, we often have a question that we need to ask our stakeholders, and we're hoping that this community will be the best place to funnel very specific questions about digital quality measures to the people who are going to be most connected to them on their end.

Ben Hamlin ([37:46](#)):

And if they can facilitate a discussion around that, that is going to be really meaningful to us being able to not only produce more digital measures, but produce more digital measures that will actually help function better in the environment, so they will be more useful to you. They will meet our goals for better measures that we're really trying to do all this work for.
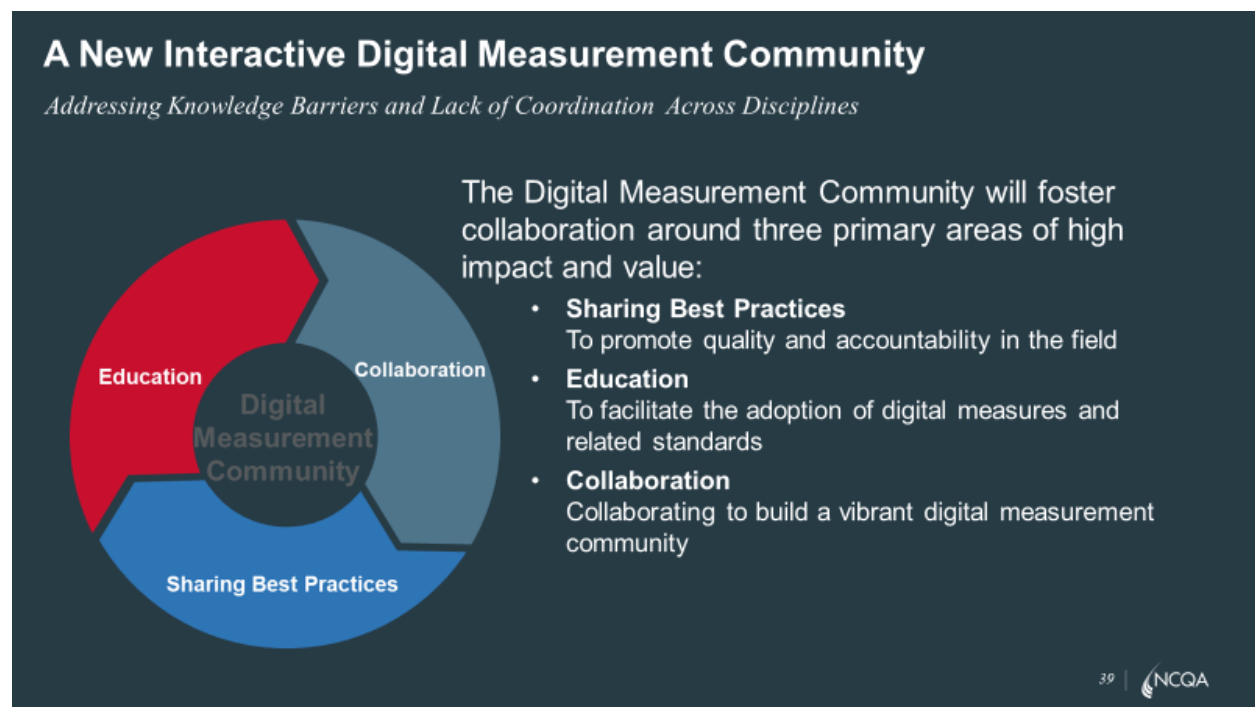
Ben Hamlin ([38:04](#)):

There's going to be a couple of different aspects to this; there's going to be some sharing [of] best practices. There will be some background information and some educational resources that we'll be providing to help those people get up to speed. And we're going to try and have a number of different viewpoints from the website and on a platform.

Ben Hamlin ([38:24](#)):

It won't just be NCQA people. It will be experts in the field, from different points of view, who'll be providing information, seeding discussions or sharing questions in this. But I really want to harp on the collaborative aspect of this. This community is designed to be an interactive community which really requires folks to communicate and collaborate.

Ben Hamlin ([38:45](#)):

And we are going to really look to the community to move these topics forward. We want to get to a place that people understand what they have to do, with the best way they might approach that. And we see this community platform as a way to do that. And so, we'll be looking forward to all of you joining the membership community and we're looking forward to all of you interacting in the community and asking your questions.

Ben Hamlin ([39:11](#)):

Again, please don't be shy once this gets launched. This will probably be launched mid-July. We're looking for the final tweaks and the technology over the next few months and [will] do some testing to make sure the platform functions and works for those customers who'll need to be using it, because again, users are the most important part of this community.

Ben Hamlin ([39:32](#)):

They become members; they become contributors; they become sounding boards. And that's really where we think this is going to advance all these principles in terms of getting better measures, getting to better quality and better accountability.

Ben Hamlin ([39:44](#)):

So finally, on a related topic. Again, part of this community is going to be breaking down the barriers between the different entities that are involved in digital quality. There are coders, there are clinicians, there are health payers, there are measure developers. There are standards experts. And one of the things we've been doing over the last few years is hosting everybody in a central location for two or three days.

Ben Hamlin ([40:09](#)):

We're in our fourth iteration now with the Digital Quality Summit. It'll be in mid-July. And it's going to be a lot of the same thing that you're going to talk about [in] the community, where we are working on cutting-edge technology. We're introducing this cutting-edge technology to people who've never even seen it or heard of it before.

Ben Hamlin ([40:26](#)):

We're engaging the different people who are breaking down the barriers. We're getting very hands-on; we're trying new things. We have no expectations. We just want to really try and see what we want to do. And so, this has been a great platform. It's been a very popular meeting. When the registration link goes live, I recommend registering ASAP because it will sell out quickly.

Ben Hamlin ([40:47](#)):

We have to really make sure that we're meeting everyone where they want to be. And again, doing this in person is always a big challenge, but we want to make this different from last year but also useful—meaningful—to those people who want to work in this space.

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Ben Hamlin ([41:02](#)):

One of the things that came out of last year's Digital Quality Summit, for example, was this idea that maybe the states wanted to get together and discuss what they need or what they're struggling with in terms of moving forward with quality and digital quality measurement.

Ben Hamlin ([41:17](#)):

Turns out they did. We had a number of states come in, and over three days, they essentially created this roadmap which lays out some of the policy issues, some of technical challenges. [The resulting] white paper is available on our website. I highly recommend, if you're interested in state-based reporting, that you look at this because recommendations from this are going to be the kind of thing we're going to be designing this year's summit around.

Ben Hamlin ([41:40](#)):

So, the recommendations that came out of last year, if they seem to still be very relevant to today, we're going to use those and try and build on them and keep them going. We're hoping that the digital measurement community as an interactive platform will essentially turn into the Digital Quality Summit 365.

Ben Hamlin ([41:59](#)):

They'll be able to continue those conversations; they'll be able to continue those introductions and peer reviews and interactions, but really help people understand what's going on and what they want to know more about. And with that, I'm going to turn it back over to Andy Reynolds, who will be taking questions.

Questions

How to ask questions after today's Q&A

Submit Your Question

PCS
Policy Program
Clarification Support

Ask a Question

My Questions

my.ncqa.org

Log in with Single Sign In

44 | NCQA
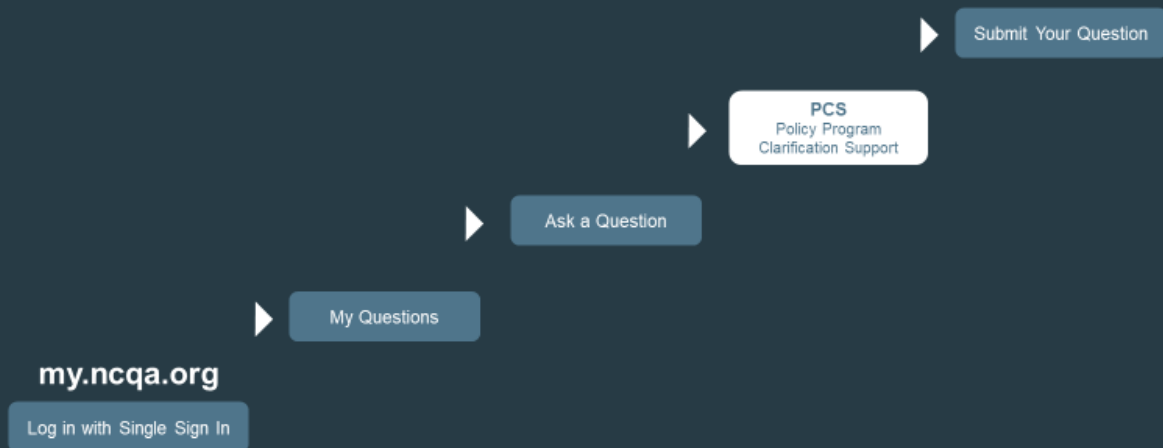
Use the Q&A chat window to ask a question

Andy Reynolds (42:20):

Good afternoon, everyone. Brandon, at WebEx, can you get back to slide 20 while I introduce the questions or answers on common questions that come in on the chat? Several people have asked if the slides will be available. The answer is "yes." This afternoon, we will post this slide deck on our website and everyone who signed up for this webinar will receive an email overnight linking to those slides.

Andy Reynolds (42:44):

The reason I asked you to take us back to this slide is we also got several questions. "Can I please see the information about these schedule changes again?" I will leave this slide up. Meanwhile, let's get to some questions that have come in, that are specific to FHIR. Several people want to know about the relationships between NCQA and CMS and the FHIR decision. Specifically, "does CMS use HEDIS and has NCQA consulted CMS in the decision to go to FHIR?"

Michael Barr (43:19):

That's a great question. I'm going to turn to Ben and Anne in a moment, but we are in ongoing conversations with CMS and the Office of the National Coordinator. While they've not made a public commitment, they are very interested in actively engaging in testing FHIR.

Peggy (43:35):

I believe that is their intention.

Michael Barr (43:35):

Right.

Peggy (43:36):

Then I think they have publicly said that they're planning to go to FHIR.

Michael Barr (43:45):

Peggy just commented and I also believe that CMS is actively involved in some of the NH7 divisions of FHIR and alternative. Ben can handle that.

Ben Hamlin (43:57):

Yes. You're correct, Michael, that CMS is very interested and involved in this idea of converting measures to FHIR. They have been facilitating the CMS contractors who do measure work to understand FHIR. I think really the only thing—and correct me if I'm wrong—the only thing they haven't said is a date and a time frame in which they'll be doing this conversion on the CMS side.

Ben Hamlin (44:17):

But I think the idea that FHIR is the model that we want to be using for all digital quality measures, whether they're HEDIS or whether different—other CMS programs—is really the ideal state. So it's just a matter of time.

Peggy (44:33):

This is Peggy again. I just want to reinforce what I've been saying and everyone to see is that nobody will be left behind here. So, if you're sitting there worrying a great deal about what we're planning to do, please don't worry. We realized we have to meet people where they are. And anything we can do to help you get ready for this, please let us know.

Andy Reynolds (45:04):

Another question related to FHIR. "What are some use cases that you would say for the FHIR strategy?"

Michael Barr (45:12):

Ben, you want to take this and maybe use some of HL7 cases that are being tested now or any others-

Ben Hamlin (45:17):

Sure. Again, when we talk about use cases, from our perspective [we're] talking about essentially a measure implementation where you need to take the specification and query it against data, but you also have to then find that data in other places. And so what we're trying to do right now with a number of different payers and clinicians and other standard experts is take the HEDIS measures and turn them into a use case.

Ben Hamlin (45:43):

So, if you're going to report this measure, what do you need to do? What data do you need to have access to, what level of specificity of that data and how fluid does the data have to be? And we try and work through to build what we're calling an "implementation guide"—essentially, an operations guide to adopting and using quality measures using the FHIR CQL standard; it's oriented mostly around FHIR because that's the major definition.

Ben Hamlin (46:08):

So again, we're working very intensively in the community to do this. We're trying to expand the major use cases. Right now we only have a couple that we're working on. And this is not just at CQL; they're also working with the Joint Commission, not only through the hospital-based measures, in this domain as well. We hope to expand that through our pilots.

Ben Hamlin ([46:24](#)):

We hope to, through this idea of piloting these other measures, to get into this domain; we will be able to get to some of those high-value measures that you want to be working on that are very relevant to you in your own worlds, and in your HEDIS world, in particular. And so, the more we're able to build practical solutions around the HEDIS quality measure—let's specify, in FHIR—the better off everybody is.

Ben Hamlin ([46:51](#)):

We have better information in terms of what we can produce, and what we provide in terms of specifications. But also on the implementer side, there's a lot more utility to having participated in that process and really have a use case, which can turn into a business case, which turns into your business proposal for the next year, in terms of how you're expecting your vendors, for example, to be collecting the data that you need for HEDIS going forward.

Andy Reynolds ([47:19](#)):

One question on FHIR. "Will you be using [FHIR] and who can participate in the pilot?"

Ben Hamlin ([47:26](#)):

HL7 is really pushing everyone to launch digital interoperability initiatives. Our quality standards though are at level of standard published right now.

Ben Hamlin ([47:44](#)):

If you are interested in participating in the pilots, please feel free to email digital.measures@ncqa.org.

Andy Reynolds ([47:55](#)):

And "May providers participate in the pilot?"

Ben Hamlin ([47:59](#)):

Absolutely. Their view on FHIR and quality measures is just as important as everybody else's. This is an open opportunity for anyone who's interested in contributing.

Andy Reynolds ([48:09](#)):

"Can you say more about the relationship between FHIR and ECDS? How do you see FHIR as relating to ECDS?"

Ben Hamlin ([48:17](#)):

Well, for those of you who aren't as familiar with ECDS, ECDS is a way to report measures that really encourages plans to look for data that's missing in their own applications from multiple sources. FHIR being this interoperability data standard, having measures in FHIR, quality measures specified in FHIR, really facilitates those data requests from those other sources, so

that a plan can compile the information needed to report an ECDS measure from three or four different sources for any one member.

Ben Hamlin (48:53):

So there's not just a matter of being able to run the measure against your data, but also to use the measure definitions to request more data back and forth, using the same standards and speaking the same language—using an interoperability standard to request data. The theory is that ECDS measures are going to be much more useful to people because they'll be able to be run much faster. And in terms of using gap identification analysis very early on in the measurement year.

Ben Hamlin (49:23):

Again, as long as these systems from the multiple places all over the map are speaking the same language and are able to communicate, share data, using language that's specified by the quality measure itself, the measure use case, we think that's going to facilitate its adoption, but also the burden of quality measurement data collection is going to be substantially reduced.

Andy Reynolds (49:48):

"How do HEDIS and FHIR relate to federally qualified health centers?"

Michael Barr (50:01):

Great question. As a chief medical officer many years ago, I know that aligning measures with federal programs is a challenge. I was chair of the board and there was always the question asked, "Can we align measures for the Bureau of Primary Health Care?" I'm not in this space now, so I don't have recent information.

Michael Barr (50:22):

Alignment has been occurring in the FQHC space. I think that is good, and to the extent that you see QMS are reported by FQHCs, that the measures that CMS put forward, or whether the measures we help create, in terms of QMS, are in the clinical quality language, and if and when—and we think when, not if—CMS moves to FHIR, those measures will also be transitioned from CQL, QDM to CQL FHIR. I don't know if anybody else in the industry team has more insights into that, but that's the extent of my limited knowledge right now.

Ben Hamlin (50:56):

Well, I just want to remind everybody that FHIR is not black box; it's an open standard that is useful for many, many different applications. FQHC… they're perhaps behind the curve in terms of digital quality realm. All of them have different reporting requirements for different entities. But the ability to access these standards and understand what language they might be getting with the requests or that they may be getting the measures in. I think it'd be very helpful.

Ben Hamlin (51:26):

It's not a secret black-box kind of approach or it's very unique to one; each individual reporting program will have different requirements and different data standards, which I'm sure makes the FQHC staff insane when they're trying to get it as measure of reports. So again, the harmonization, the integration, the communication is all going to be standardized across many, many different aspects. So hopefully it'll make that much easier for them to do quality measurement.

Andy Reynolds (51:49):

"Will large multi-specialty provider groups be required by payers to develop FHIR files for submission?"

Anne Marie Smith (52:01):

How the data is transmitted to a payer can still be up to the payer, so they could potentially start taking FHIR resource files from a physician. There are many EHRs that have been working in the FHIR space to develop exports from their EHRs that use FHIR. But the data could come to the health plan in whatever format the health plan likes, because it will get integrated by the health plan into their database and then run against, or with, the FHIR measure.

Anne Marie Smith (52:39):

Because there's that intermediate database populated, health plans do not necessarily need to receive the data in a FHIR format; however, the less conversions that take place with the data, the more consistent it is and the more sure that your data represents the source. Ben, were you going to add to that?

Ben Hamlin (53:05):

I was going to say, remember that the health plans are going to be requesting data from providers, as they always have, and if they push out on a data request in FHIR [it's] because that's what the measure is telling them, what that measure needs. The efficiency of being able to turn those requests around, I think it's going to really reduce the burden of point of care because the clinicians and the EHR platforms are figuring out how to handle these FHIR requests.

Ben Hamlin (53:31):

And that's part of what our work with HL7 is doing, in terms of understanding how big can we make these requests without overburdening their systems. But also, how can we remove that? The need for a person that manually has struggled with information, send it back to the health plan, which is just costly, burdensome and time consuming. And if you can drop that from months down to milliseconds, I mean, that's a fantastic win for everybody involved.

Andy Reynolds (53:56):

Let's knock out a few last questions. One is about security. The other is about the international use of FHIR. On the security side, "are data security experts involved in protecting data moved to the cloud or data shared among different entities?"

Ben Hamlin (54:10):

Yes. So, we should say that within the FHIR community there's an entire security and privacy sector [to which] all of that—I don't want to say "assumes," but it all applies. So, all of the best practices in terms of security and privacy and confidentiality are being hammered out as we do expose more of this data through these security APIs.

Ben Hamlin (54:33):

It also has to fall under HIPAA; it has to follow those same rules. And there's a different work groups within the NH7 community that work on the various specific aspects of the financial

aspects, the security aspects, the privacy aspects and so on and so forth. So I hope that answered the question.

Andy Reynolds (54:53):

Thank you. Ben. Final question has to do with the international use of FHIR. "Has it been used overseas and what are the results there?"

Ben Hamlin (54:59):

FHIR is actually originally from Australia, or from an Australian, I should say. I don't know the extent to which different systems have fully deployed it. But again, it's a standard tool that defines health care data. And health care data doesn't necessarily change when you change countries because physiology—people do stay fairly similar—and also this idea of these large research studies; there's a lot of standardized data in different countries.

Ben Hamlin (55:31):

If they're all against speaking the language, you can compile them together and look for rare events, rare diseases, and get a lot more information.

Ben Hamlin (56:06):

So, FHIR does everything, which is great. The problem is, FHIR does everything. So you do have to draw the guardrails in a bit for specific use cases like the U.S. health care system. There's a further restrictive profile called QI Corp, which is the quality improvement corp. For quality you use a slightly more constrained version of FHIR, because there's certain definitions that say, you must do this and you have to do this, so you can actually do this. Whereas FHIR maybe has a different set that makes it a little bit more expansive.

Michael Barr ([56:33](#)):

Great. Thank you everybody. Ben and Andy, Peggy, thank you very much for contributing to the webinar, and to all of you who joined us today for episode five. As Andy mentioned earlier, everyone who attended the webinar will get a link to the recording. The slides will be up later today, recording and transcript to follow in the next few days.

Michael Barr ([56:52](#)):

Thank you very much. Look for posting about future webinars and if you have any suggestions about topics, please let us know. With that again, thank you very much. Have a great rest of your day.