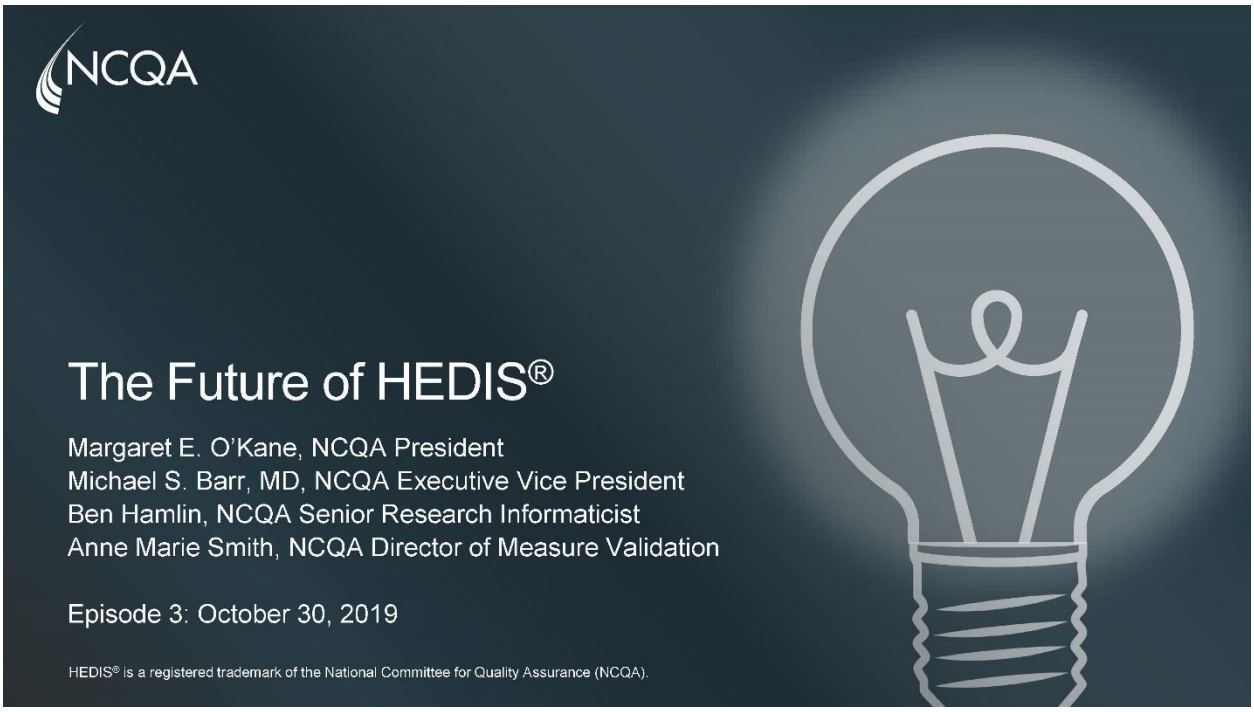
The Future of HEDIS: Episode 3—October 30, 2019



Brandon:	00:23	Hello, and welcome to today's webinar, Let's Get Technical: Digital Measures and ECDS. This is the third webinar in The Future of HEDIS webinar series. My name is Brandon and I will be in the background answering any WebEx technical questions. If you experience technical difficulties at any time during this WebEx event, please submit your technical issue in the Q&A panel and I will assist you. You may also contact our WebEx technical support at 1-866-779-3239. Please note that as an attendee you are part of a larger audience. However, due to privacy concerns, the attendee list is not displayed. All attendees will be in a listen only mode throughout the duration of today's call. And as a reminder, this call is being recorded.
Brandon:	01:04	We will be holding a Q&A session at the conclusion of today's presentation. You may ask a question at any time by entering it into the Q&A panel at the lower right side of your screen. I would now like to introduce your speakers for today. Peggy O'Kane, Michael Barr, Anne Smith and Ben Hamlin. Peggy, you now have the floor.

22	Peggy O'Kane:	01:23	Thank you very much. I just want to welcome everybody. We have 700 people, and still climbing, on the webinar. So, thank
24			you for being here. And I particularly wanted to welcome the 30% of the people in the group who are new attendees. This is
26			the third webinar of this series, and if you couldn't attend the prior ones, they're online at ncqa.org.

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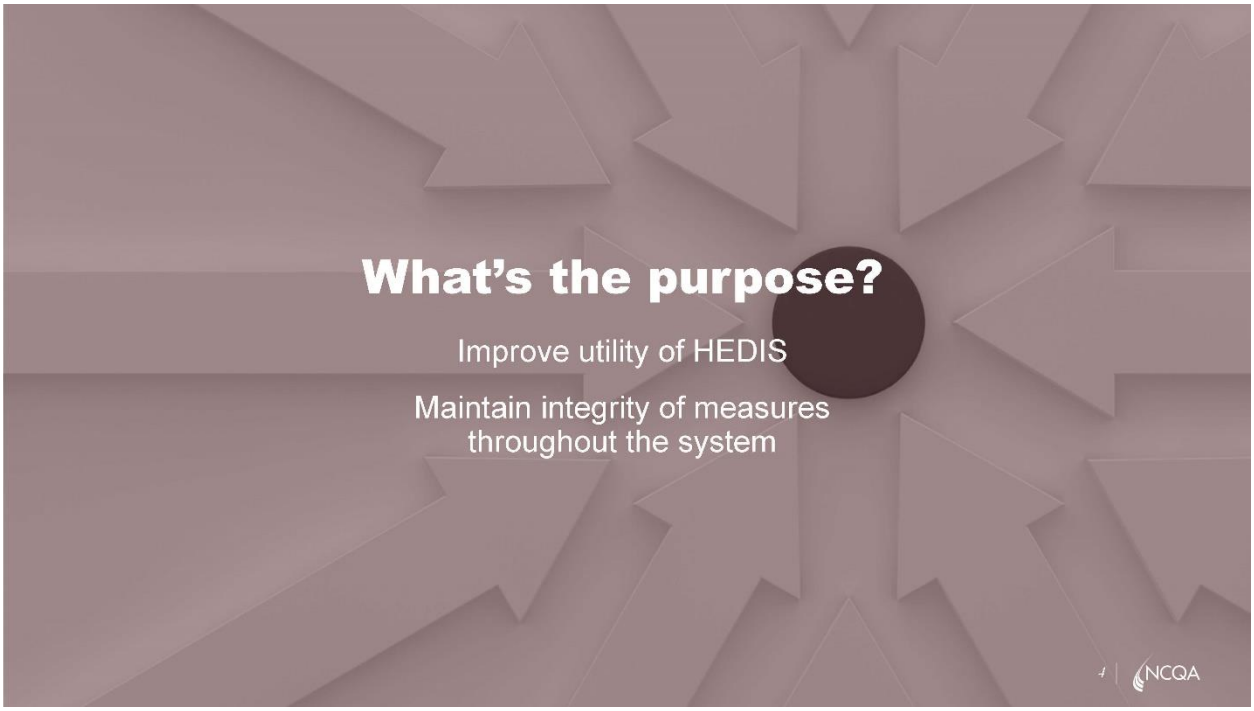
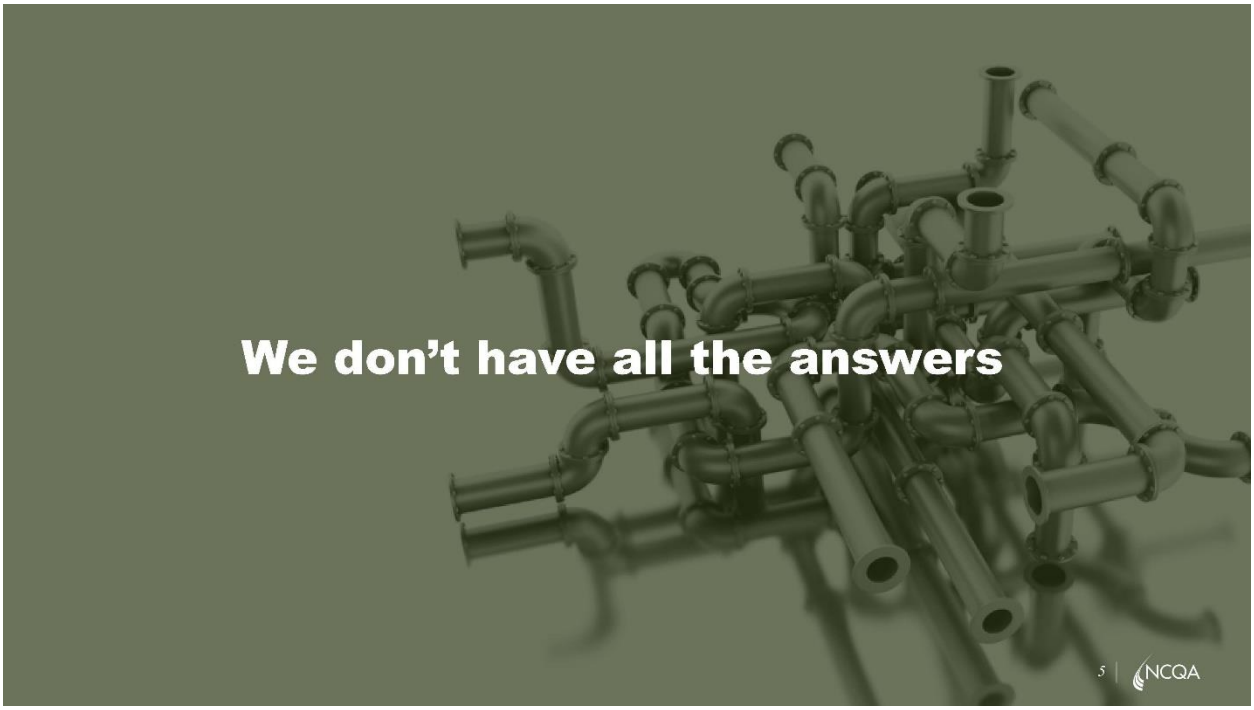
Peggy O'Kane: 01:51 So I'm going to be reviewing some things at this point. So, why are we changing HEDIS and why now? Well, if you think about it, HEDIS has been continuously evolving over time. But I think we're at a point of real change in the health care environment, where we have a lot of digital information at the point of delivery of care; we have new capabilities for care management and so forth at the point of delivery of care.

Peggy O'Kane: 02:23 We've been getting feedback that the old way of doing it really holds us back from measuring what really matters. And, we've done some market research. And while we know that some people are worried because this is a complicated enterprise, we are committed to making this work for everybody. But the market research that we've done: We thank those of you who have participated in it and thank you so much for sharing your point of view and what's happening on the ground.



Peggy O'Kane: 02:59 So, what is the purpose of changing HEDIS? Well, we want to improve its utility and we want to maintain the integrity of measures throughout the system. In the past, we've often had a HEDIS measure that a plan was reporting and then medical delivery systems were kind of doing a take-off of the measure to report it up to the plans. But that was kind of happening in an inexact way and [in] different ways for different people.

Peggy O'Kane: 03:28 So, we're trying to have measures that are coherent up and down the delivery system. And we believe that will eliminate a lot of the noise and variability among measures.



56	Peggy O’Kane:	03:43	And I also want to rush to say, and I guess I think we all need to remember this throughout this call—and all the time—we don’t have all the answers. If you look at that picture, I think it suggests that we’re dealing with a complex system and it’s not the same everywhere. So, we are proceeding with all deliberate speed, but also wanting to listen to you and hear from you about things that we didn’t anticipate.

64	Peggy O'Kane:	04:12	The changes will be gradual. We are viewing change here as a process, not an event. It's a collaboration. It's not [a] command from NCQA. And we're aware that readiness varies, so the pace will vary. So, readiness of plans varies, readiness of the delivery system varies and everything that feeds into this really will vary. This is why we must be very deliberate and make sure that we are paying attention to what's happening as we're trying to do this.
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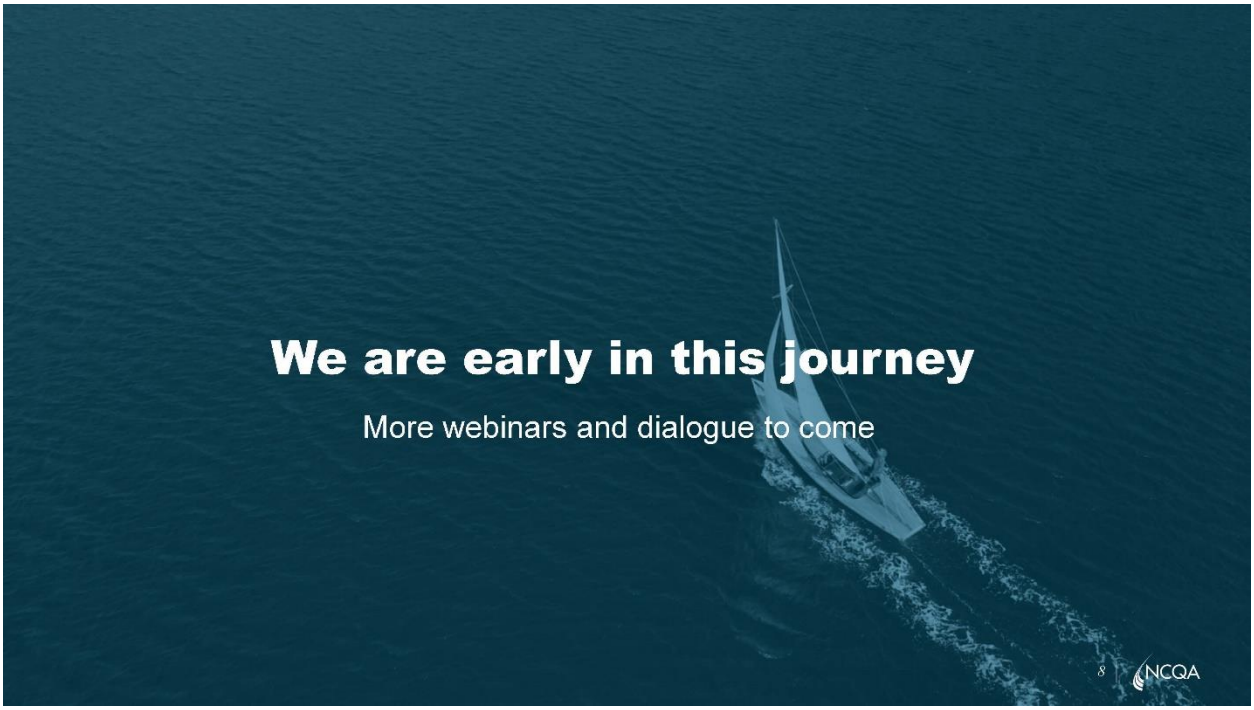
Peggy O'Kane:	04:56	I do have an announcement. On October 31st, tomorrow (I guess it's an accident that it's Halloween), we're releasing eight digital measures that are now specified in the new way that we're thinking about. Some of you are ready to embrace those; some of you will be interested in seeing what they look like, I think. But I think this is another important step forward to get us into the future that we all want to be in.



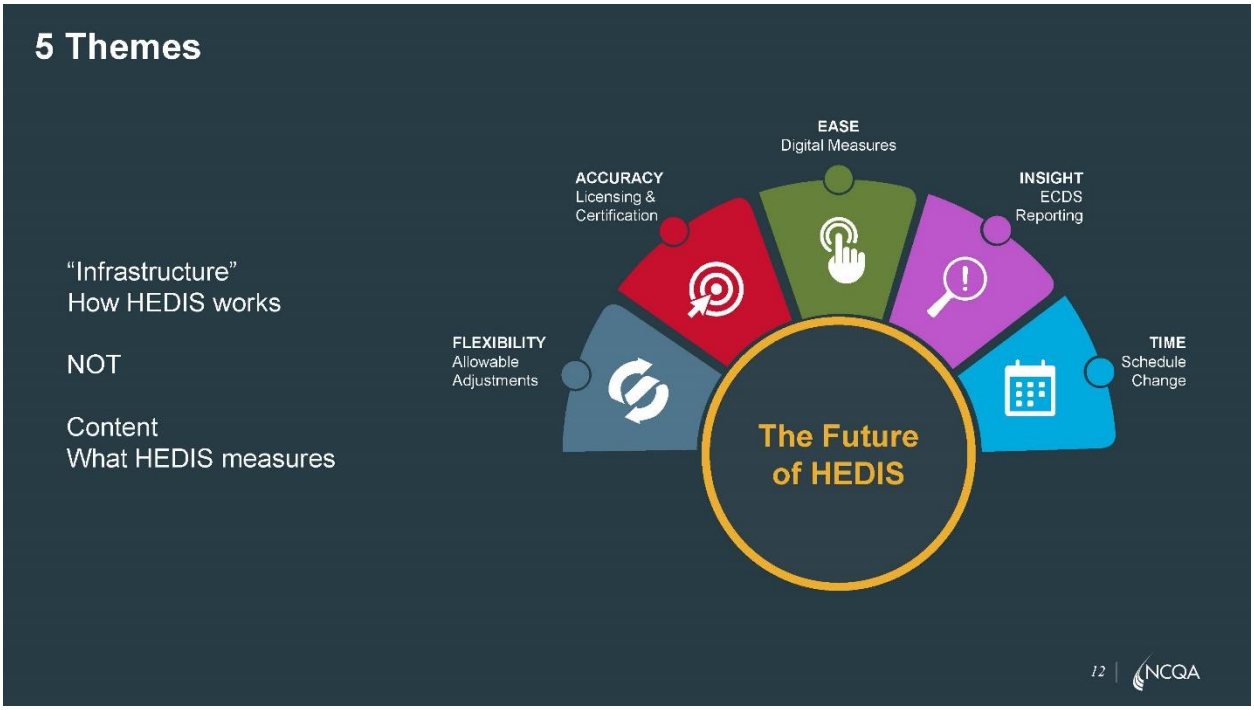
Peggy O'Kane:	05:30	We're early in this journey and we're committed to doing a lot of dialogue with you. These webinars are part of that and we'll talk more about what else we have in mind, to make sure that we can stay in touch with all of you who are trying to figure out how to get this to work.

Peggy O'Kane: 05:48 I think I just said this, but you can find our earlier webinars on ncqa.org, Future of HEDIS. And I think they will be helpful, and if this one feels confusing, then it'd probably be good to go back and look at those other ones. Even if you were there for the other ones, sometimes it may be helpful.

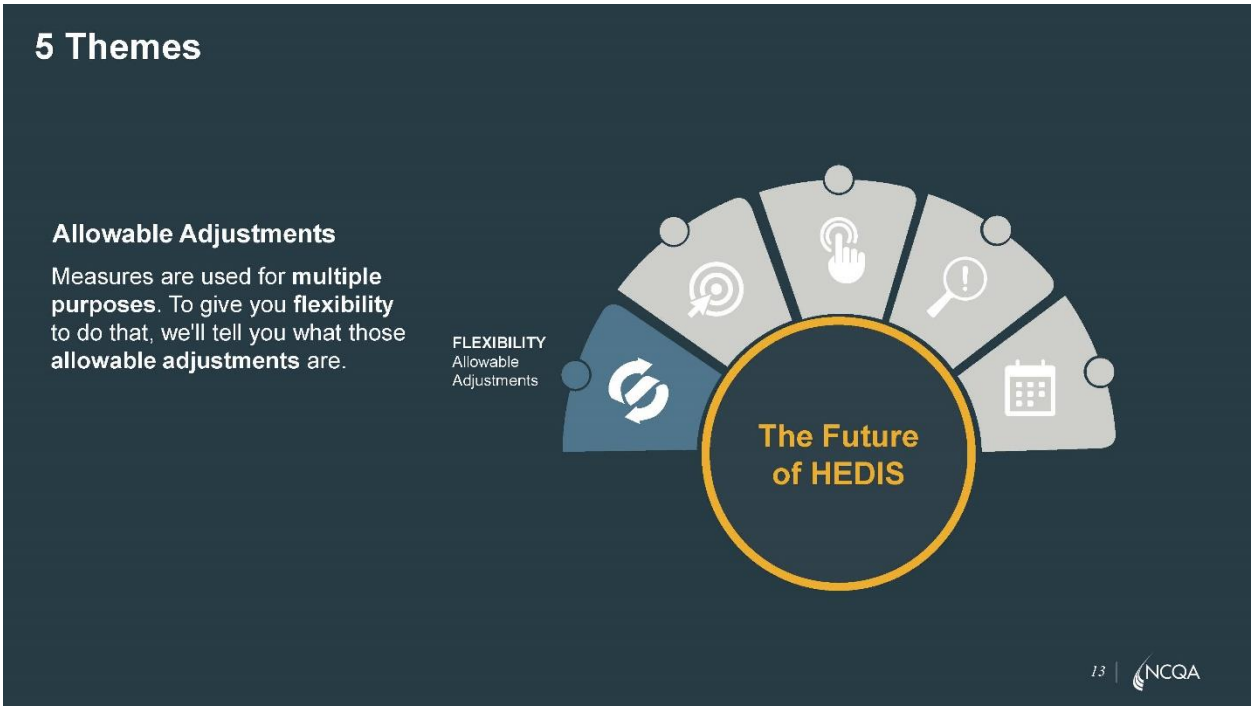
And then we have one webinar coming up on December 10th, so please save that date and look for invitations for future webinars.

Peggy O'Kane: 06:26 And now we're going to turn this over to Dr. Michael Barr, our Executive Vice President—and really, the thought leader of this work. So, thank you, Michael.

Michael Barr:	06:37	Thank you, Peggy. Welcome, to everybody. And I know that 30% of you are new. Some of you are returning guests, and we ask your indulgence as we do some level setting and cover some of the same things we've covered in the prior webinars. And then we'll go rapidly to the key part of this webinar, which is sort of to derive some deeper technical insights to what we're trying to do. And that's where Anne Marie Smith and Ben Hamlin will take over.



108	Michael Barr:	07:05	So, let me just cover the five themes. These are the topics that we're going to talk about very quickly. It's about the HEDIS infrastructure, not [about] what the HEDIS measures contain. And those are allowable adjustments, licensing and certification, digital measures, electronic clinical data systems reporting and the schedule change for HEDIS. And as I mentioned, Anne and Ben will focus on the digital measures and the electronic clinical data systems reporting.



Michael Barr:	07:33	So, allowable adjustments. That's kind of a new flexibility for use of HEDIS. And we introduced this with HEDIS 2019 to help users adjust to HEDIS measures without changing their clinical intent or undermining the integrity of measures. That's what Peggy was saying earlier.
Michael Barr:	07:49	We listened to how organizations were using HEDIS and decided that in order to promote the effective use of HEDIS measures, not on the health plan level, but at the practice or accountable entity level, we needed to provide guidance by specifying what those allowable adjustments are.
Michael Barr:	08:05	For example, allowable adjustments include turning off eligibility for enrollment criteria, filtering by product lines or focusing on subpopulations using the original measure specification. All of those are allowable, whereas changing the clinical content or the clinical specifications would not be allowable.

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	Michael Barr:	08:27	The next topic is licensing and certification. While we're providing the flexibility to allow the adjustments, we also want to ensure that the use of the measures is appropriate and the results produced are accurate. In other words, back to that "integrity" word. You need to ensure the integrity of the measurement system; therefore, we are emphasizing that proper licensing and certification occurs.
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140	Michael Barr:	08:51	Using HEDIS measure specifications requires a license agreement with NCQA. If you use HEDIS internally for quality improvement within your health plan or delivery system, we count that as noncommercial use. The standard license agreement you attest to in the NCQA store when you purchase Volume 2 is all you need for those uses.
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146	Michael Barr:	09:11	However, if you have a health plan that uses internal software to report HEDIS measures or rates, you must have a separate HEDIS license and be certified by NCQA. In other words, if you sell services or software to use HEDIS measures, you must first receive an NCQA measure certification to demonstrate that how you use our measures meets our standards.
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152	Michael Barr:	09:33	The point of licensing and certification is to help ensure [that] HEDIS results are accurate, reliable and can be used for all the purposes you intend, and most importantly, improving health care.
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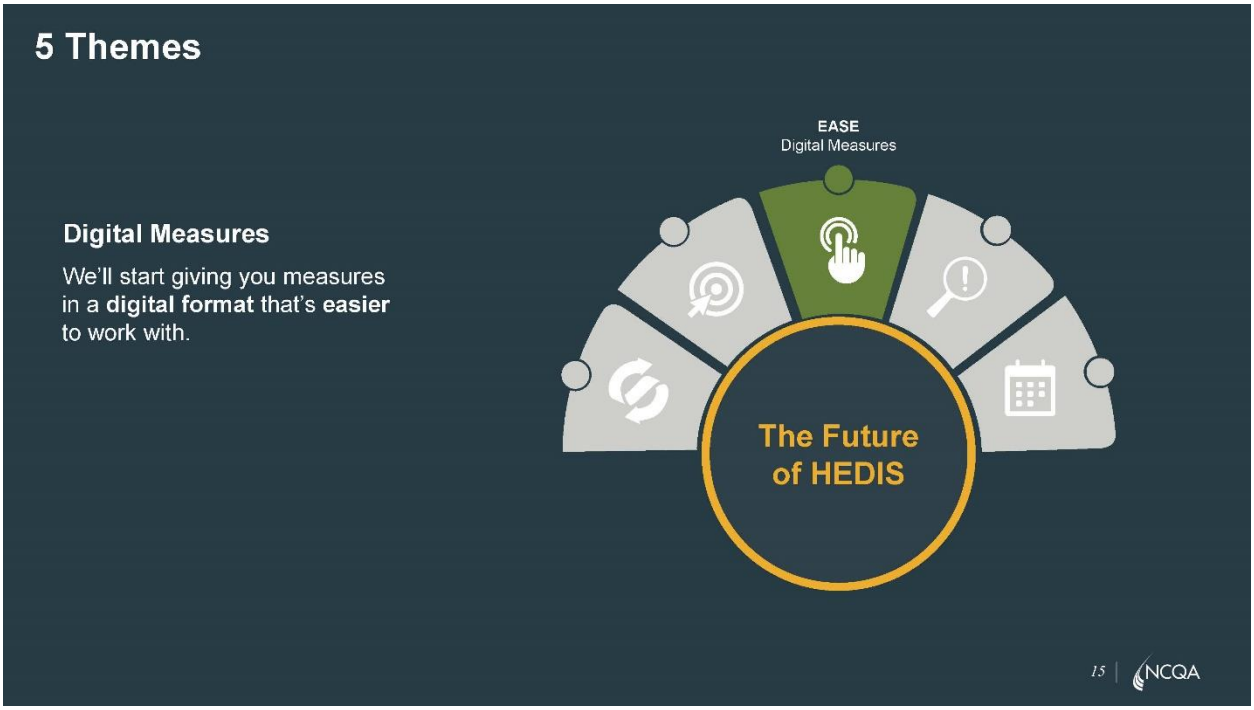

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	Michael Barr:	09:47	Next topic is digital measures. Right now, I'm talking about the
158			digitalized versions of existing HEDIS measures; the eight
160			measures that Peggy announced are going to be released
162			tomorrow [and] that are reported in the traditional way. In a few minutes, I'll talk about electronic clinical data systems measures, which are also digital, but have a different reporting format. And
164			then, Anne and Ben are going to go into that in much more detail than I will.
	Michael Barr:	10:12	As Peggy mentioned, we're going to release eight measures for
166			traditional reporting that are digitally specified, tomorrow. These
168			will be machine readable and downloadable from the NCQA store. Anne will list those eight measures later for you. NCQA
170			digitalized these measures so users don't have to. You heard about the many programming hours spent by organizations,
172			translating the PDF version of Volume 2 into computer code: upwards of 50-plus hours per measure. Now, with the launch of
174			these measures, we're providing those specifications using industry standards, the Quality Data Model and the Clinical
176			Quality Language, also called QDM and CQL for short. We're also exploring the use of FHIR and we welcome your input on whether you are currently using Fire or not.
178	Michael Barr:	11:05	We believe that the use of these digitalized versions of existing
180			HEDIS measures not only saves time but will help avoid human error and non-standardization. And before I forget, let me invite
182			you to join our Digital Measurement Community. We're building an online forum as another communication channel for information from NCQA, but more importantly, to allow
184			stakeholders from around the country to share best practices

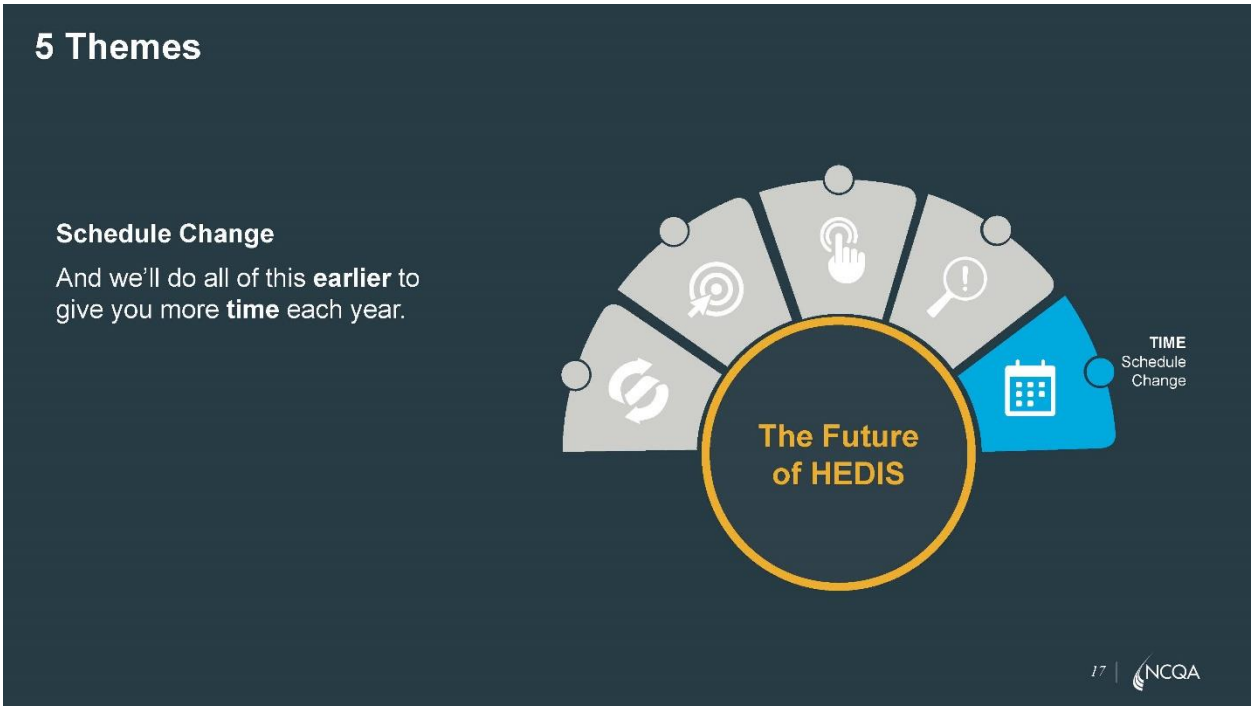
and share ideas about moving the whole quality enterprise towards better quality measures. You can join the mailing list and register at ncqa.org/dmc.

Michael Barr: 11:41

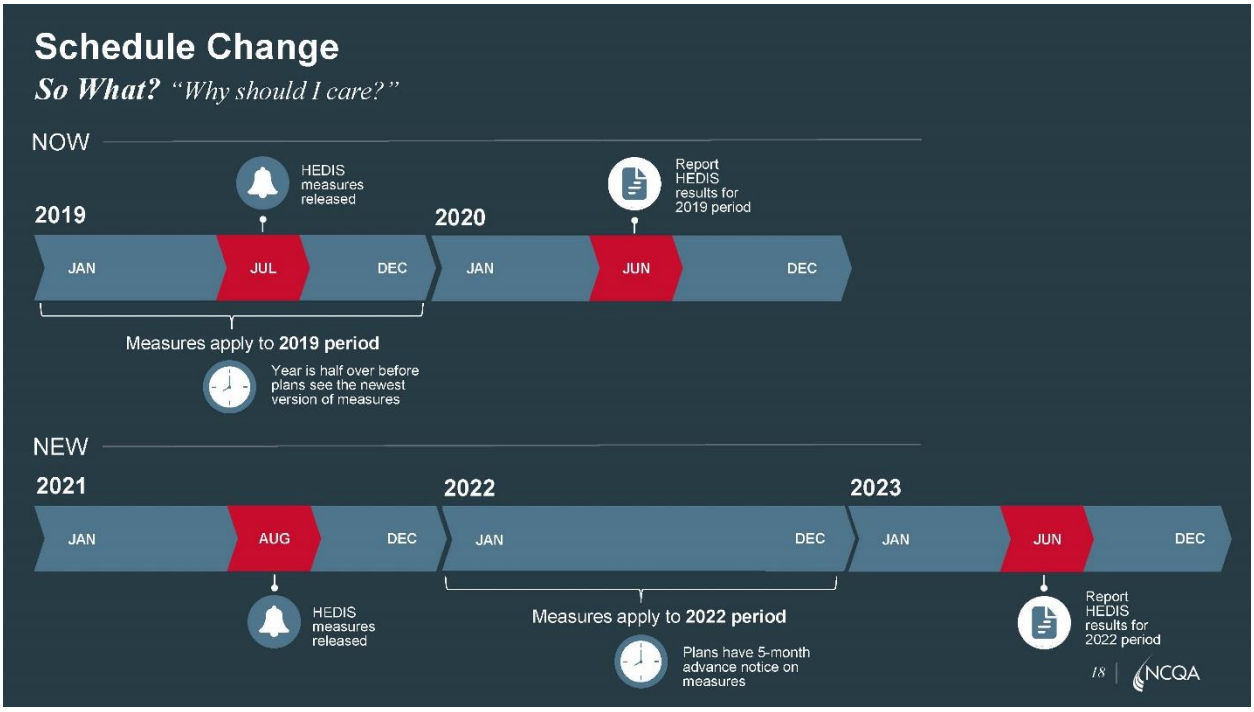
And now, electronic clinical data systems. This is a subset of the NCQA digital measure portfolio. In other words, all ECDS measures are digital, but not all digital measures are ECDS. These measures rely more extensively on the data that clinicians and patients generate as care is delivered. They have the same benefits of the digital measures I just referenced: Reduce programming burden, [improve] accuracy and better standardization. And they orient quality measurement towards greater use of electronic clinical data, while still leveraging data sources used for traditional reporting.

Michael Barr: 12:17

So, data used for ECDS measures are reported into four categories according to their source. EHR is first. Two, registries or health information exchanges. The third is case management systems. And the fourth are administrative files, including claims. Because we anticipate that clinical data will become more available over time, we believe ECDS measures are the future of clinical quality measurement; combining claims data with the data from EHRs, open information exchanges and other electronic sources can provide better insights with the quality of care being delivered to individuals and populations.



210 Michael Barr: 12:52 And the last topic I'm going to talk about is the schedule change.

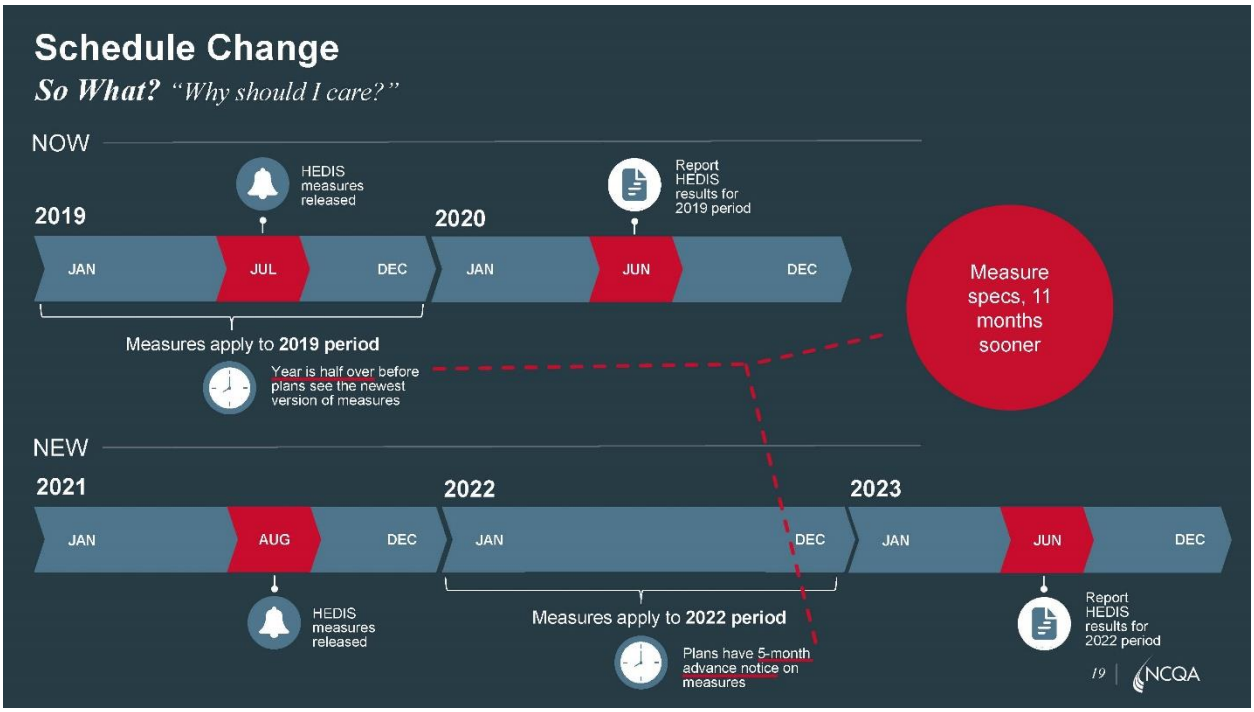


212 Our traditional schedule is to release measure specs in HEDIS Volume 2 halfway through the year in which the specs are to be
214 used. For example, the measures we released in July of 2019 apply to services this entire calendar year, from January 1st to

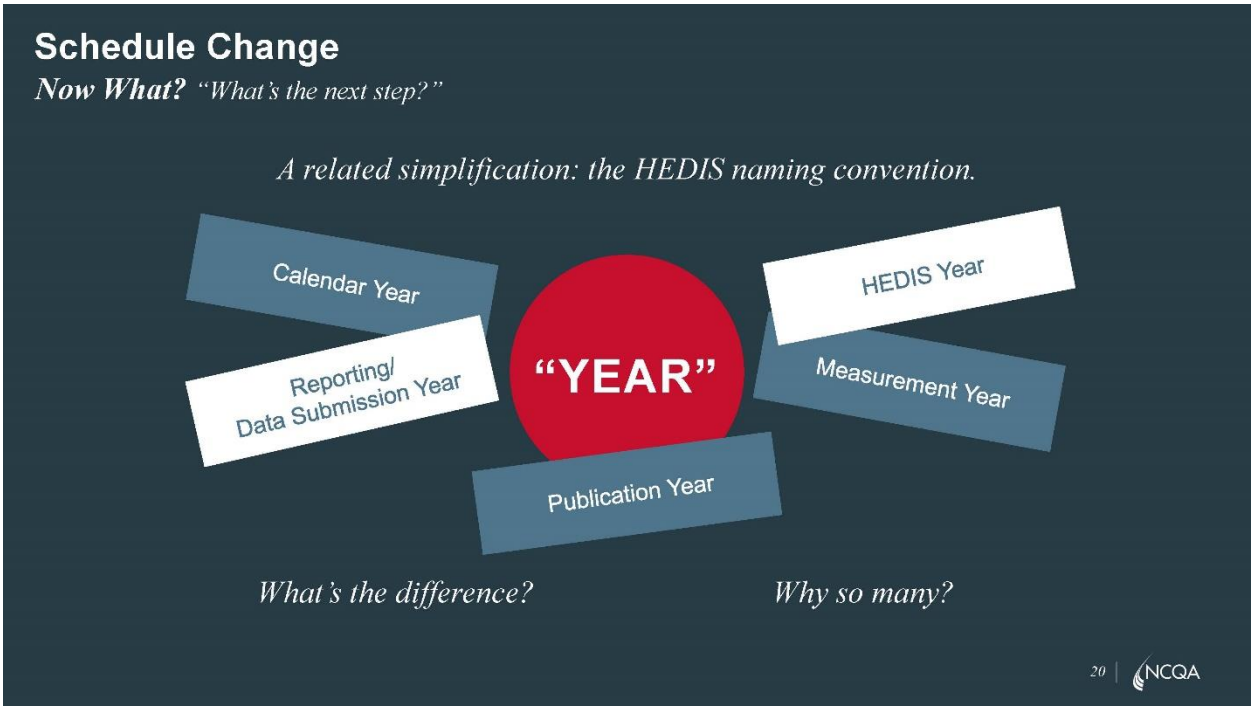
December 31st. That means that the measurement year is half over before plans know what they're expected to report. This six-month lag has been a feature of the HEDIS cycle for decades, and we think we can do better.

Michael Barr: 13:29

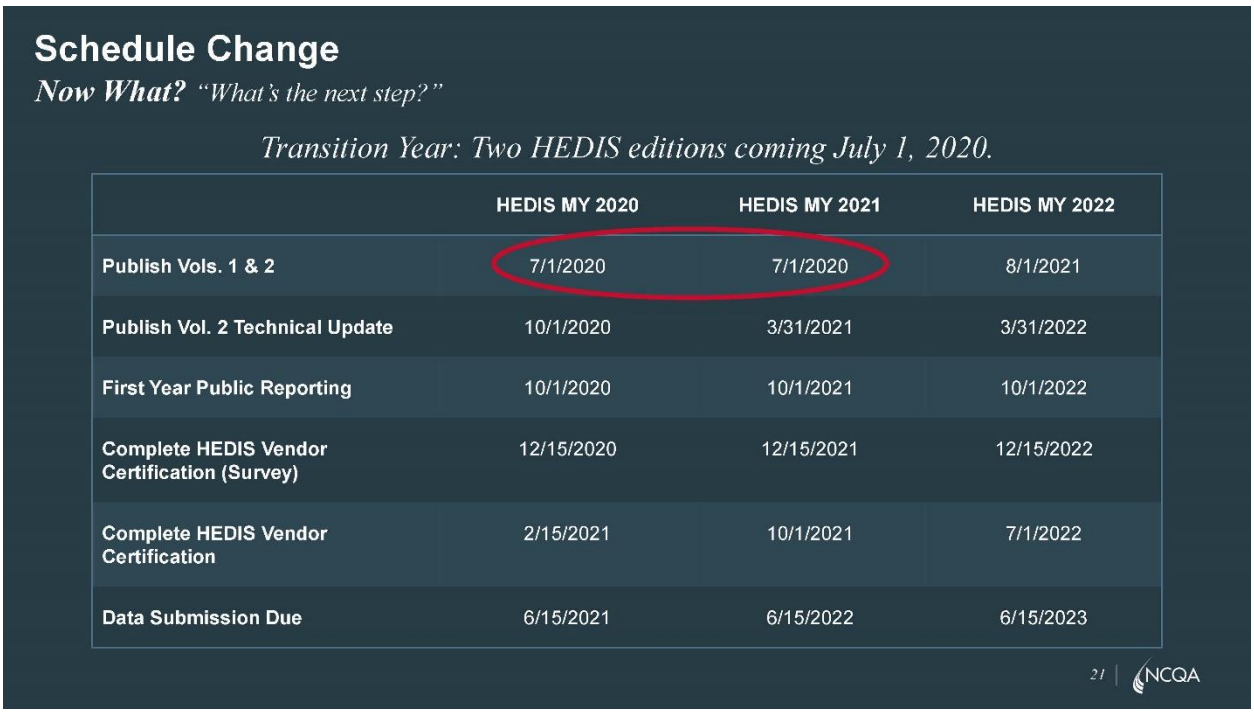
So, here's the new way. If you look at the bottom of the slide, on August 1, 2021, we will release measures, but these measures will apply to services in 2022. In this model, health plans will have a five-month lead time on what the measures will be. Note that we are not changing the HEDIS submission deadlines. Reporting the data will still happen in June of the year after the measurement year, same as it always has.



Why does that matter? Because you'll get measure specs 11 months sooner.



Michael Barr: 14:04 Now, in addition to this, we're making one other change. We know that the word "year" can mean at least five things in connection with HEDIS. So, what we're doing is, starting in calendar year 2020, the HEDIS volume will be named based on the measurement 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

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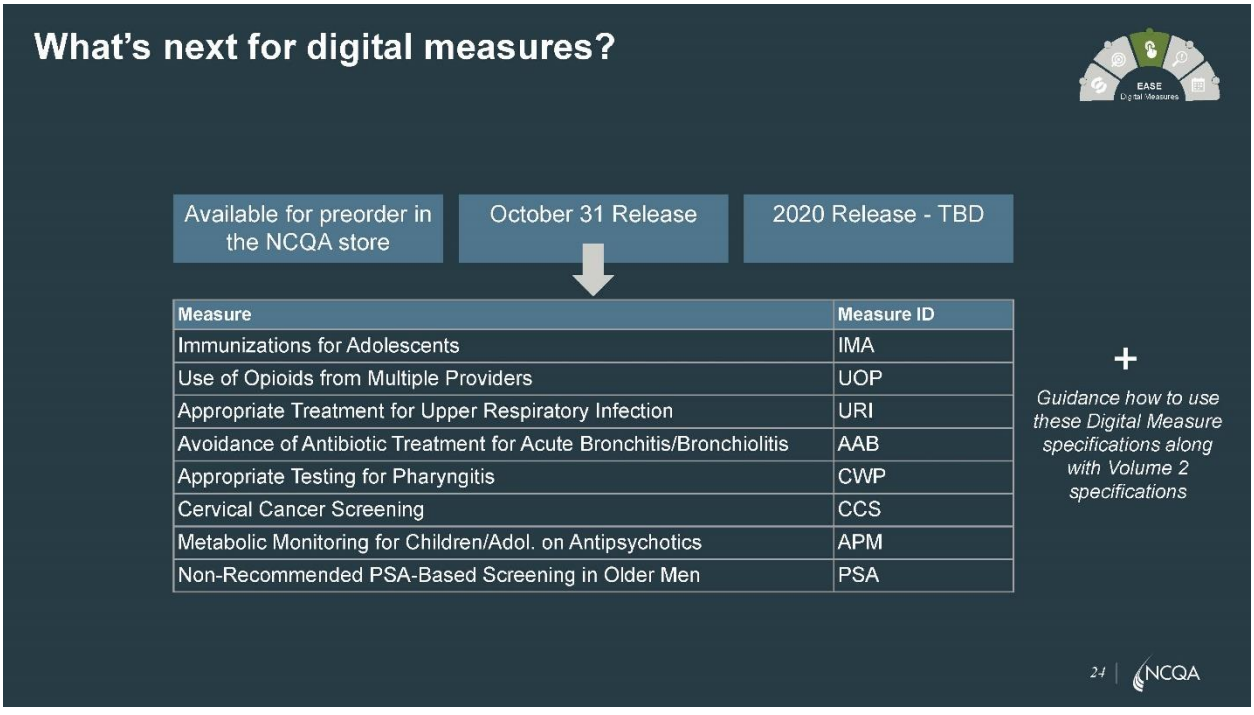
This table shows the various parts of the annual HEDIS cycle we've evolved. And of course, it's [a] complicated table to look at in a webinar, so I encourage you to download the slide from the website. But the most important part of this slide is in the red circle. On July 1, 2020, we will publish measures that will apply to measurement years 2020 and 2021. This will be a transition. Now, we're happy to take questions about this in the Q&A.

Michael Barr: 14:55 So, those are the five areas: allowable adjustments, licensing and certification, digital measures, ECDS reporting and schedule change.

Michael Barr: 15:05 And now, I'm going to turn it over to Anne Smith and Ben Hamlin, who will get to the heart of today's presentation: more technical information about the digital measures strategy.

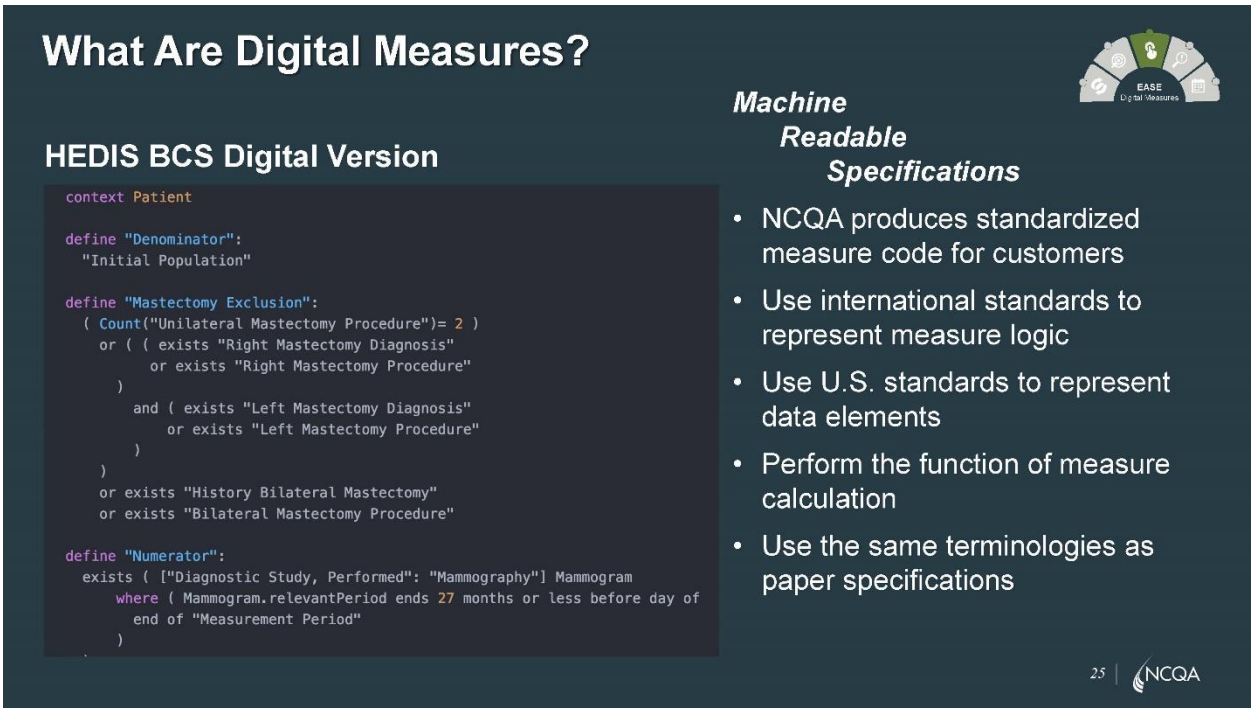


Anne Marie Smith: 15:18 Thank you, Michael. And welcome, everyone. I am going to start out by showing you exactly which measures are going to be

released tomorrow. As Peggy announced, we are releasing eight digital measure packages for measures that have been traditionally in HEDIS. And one question I hear people asking is, "It's well after the release from July 1st and from the October Update. Why now?" And I think part of it is the excitement that we have these measures in digital packages. And we want you to be able to see them, start working with them and figure out how you are going to produce HEDIS measures in the future.

Anne Marie Smith: 16:01

So, we know that this release is late for this year, but we're hoping that people can start analyzing these, looking at them, understanding them and learning about digital measures.



Anne Marie Smith: 16:12

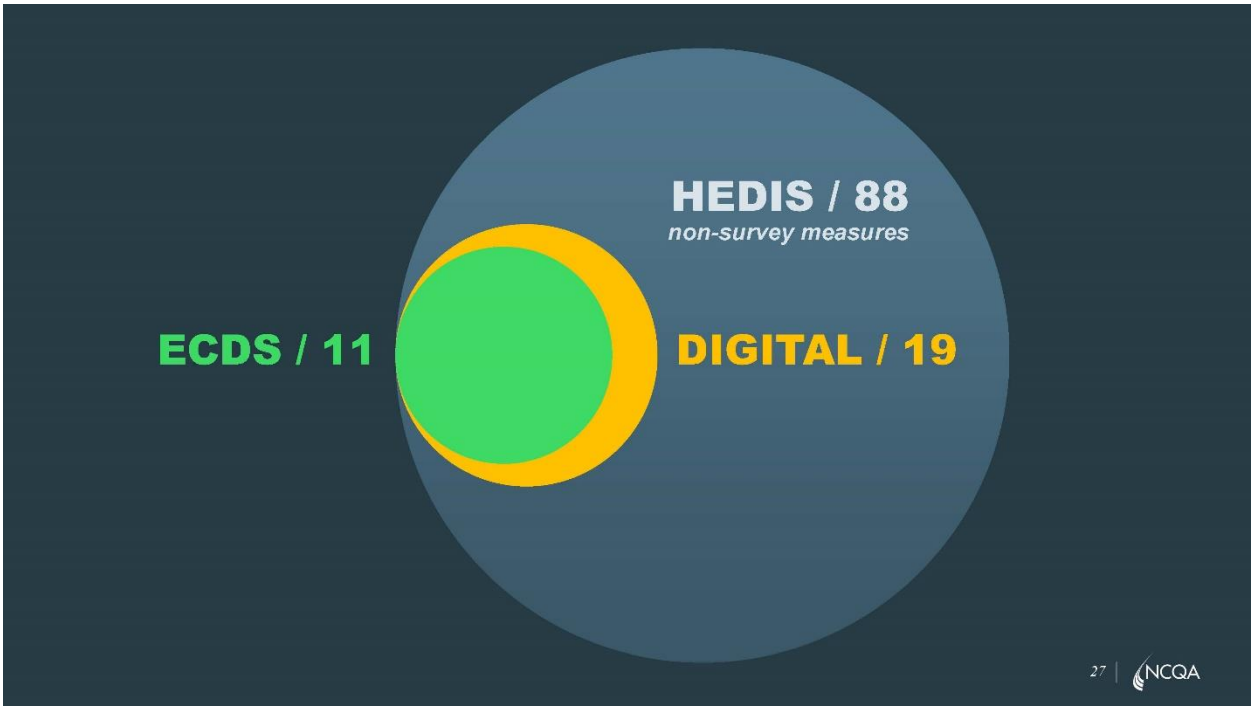
So, what is a digital measure? A digital measure is a measure that has been put into a standardized format. As you know, we release the measures every year in a PDF format in the English language. And the English language has many nuances to it. These digital measures are in a standardized format with standardized phrases and using a language that is swiftly becoming an industry standard for how to express quality measures.

Anne Marie Smith: 16:51

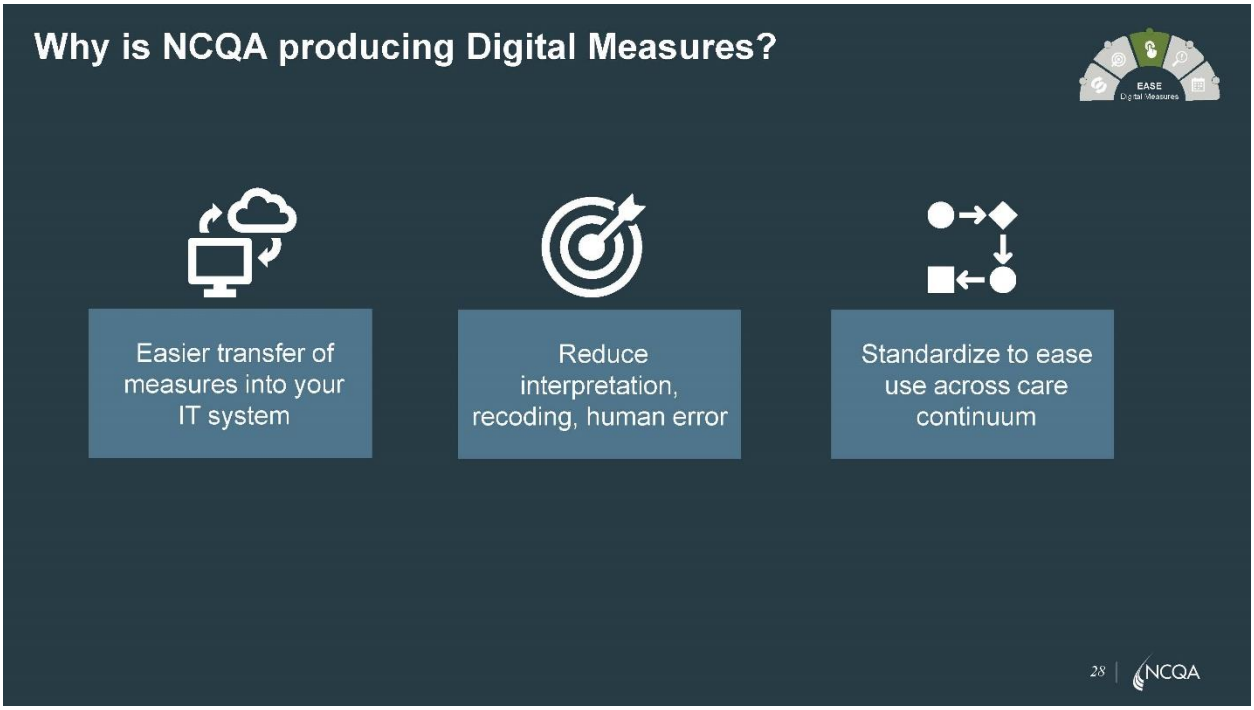
It uses two standards, as Michael talked about. It uses QDM, or the Quality Data Model, as the data model for these standardized measures. And what that means is the QDM is really the noun. I think of it as the noun of the sentence. So, I want to talk about an encounter, I want to talk about a diagnostic study. And maybe that diagnostic study I want to talk about

282			happens to be a mammogram. So, the quality data model is really identifying the nouns in the sentence.
284	Anne Marie Smith:	17:26	The second standard we're using is Clinical Quality Language. This language specifies the logic. So, it's looking at the relationships between the data elements or between the data elements and their attributes. For instance, it shows you how two different data elements are related. This diagnosis needs to start before this encounter. This diagnostics study needs to happen in the 27 months prior to the end of the measurement period.
290	Anne Marie Smith:	18:02	So, it is very specific phrases. It is very specific relationships defined between the elements. And those are the two pieces that make up these standardized measures. When you see the measures in this format, you know [that] these are digital measures.
296	Anne Marie Smith:	18:20	With a digital measure package, you get a couple [of] things. You get what's pictured on the left here, which is a human-readable version of that specification. You could take this human-readable version of the specification and use it to write or update your existing code. It shows you in a very standardized way, with very standardized phrases, exactly how the measure should be calculated.
302	Anne Marie Smith:	18:46	In addition, you also get several versions of machine-readable code. Because the measure is built to a standard, programmers could develop a program to analyze the content and calculate the measure from the logic that we provide in these machine-readable packages.

308	Anne Marie Smith:	19:07	So now, that brings me to the first myth. And if you've been listening carefully, you know the answer to this myth already. Our
310			first myth is, all ECDS measures are digital and all digital
312			measures are ECDS. And if you've been listening very carefully to what Peggy said, what Michael said, and what I announced as the new measures, you will know that this myth is not true.
314	Anne Marie Smith:	19:32	ECDS measures can be represented in a digital format, but traditional HEDIS measures also can be represented in a digital
316			format. And that's how we're going to release what we're releasing tomorrow: eight of the traditional HEDIS measures that
318			are now represented in a digital format. The format is what makes a digital measure. Not the content of the measure or
320			what's used to calculate it or anything else. It's really the format of the measure.



Anne Marie Smith:	20:03	I'm going to show you a graphic that shows you a little bit about how HEDIS is divided now with these new digital measures. And these counts do include the measures that are coming out tomorrow. HEDIS has about 88 non-survey measures in it. With tomorrow's release, 19 of those are going to be digital measures. 11 of those are in the ECDS domain within HEDIS. So, just a little graphical representation of what we've been talking about with digital measures.



332	Anne Marie Smith:	20:43	Digitization means that we at NCQA can write the measure in a standard format. What does this get you? Why are we producing this digital measure? Well, it really eases the need for you to read, interpret and recode the measures. And 20 years ago, before I was at NCQA, one of my jobs was to program HEDIS every year, or at least review HEDIS and help the programmers determine how they were going to program the measures for the health plan.
340	Anne Marie Smith:	21:16	And the first thing I would do when I would get my HEDIS volume in July would be for me to sit down and I'd put my old volume and my new volume side by side. And I'm hoping you people out there who help calculate HEDIS are getting a good laugh out of this. But I would put my two volumes side by side and I would look through and identify all the changes between last year's HEDIS and this year's HEDIS. And then sometimes a word would change and I would have to think about that word very carefully. And I would be like, "Did they mean to change that word? What meaning has changed because of that word? Do I have to change anything in my program because that word changed?"
352	Anne Marie Smith:	21:56	And so, there would be hours of thinking about all these things and all these wording changes and what they meant for our program. And a lot of that interpretation doesn't need to be done anymore. We're using standard phrases with these digital measures. Starts before the startup, starts during. So, again, if the standard phrase changes, then there's a change in the measure. And if the standard phrase doesn't change, there's no change. With this, we're able to help avoid some of that human

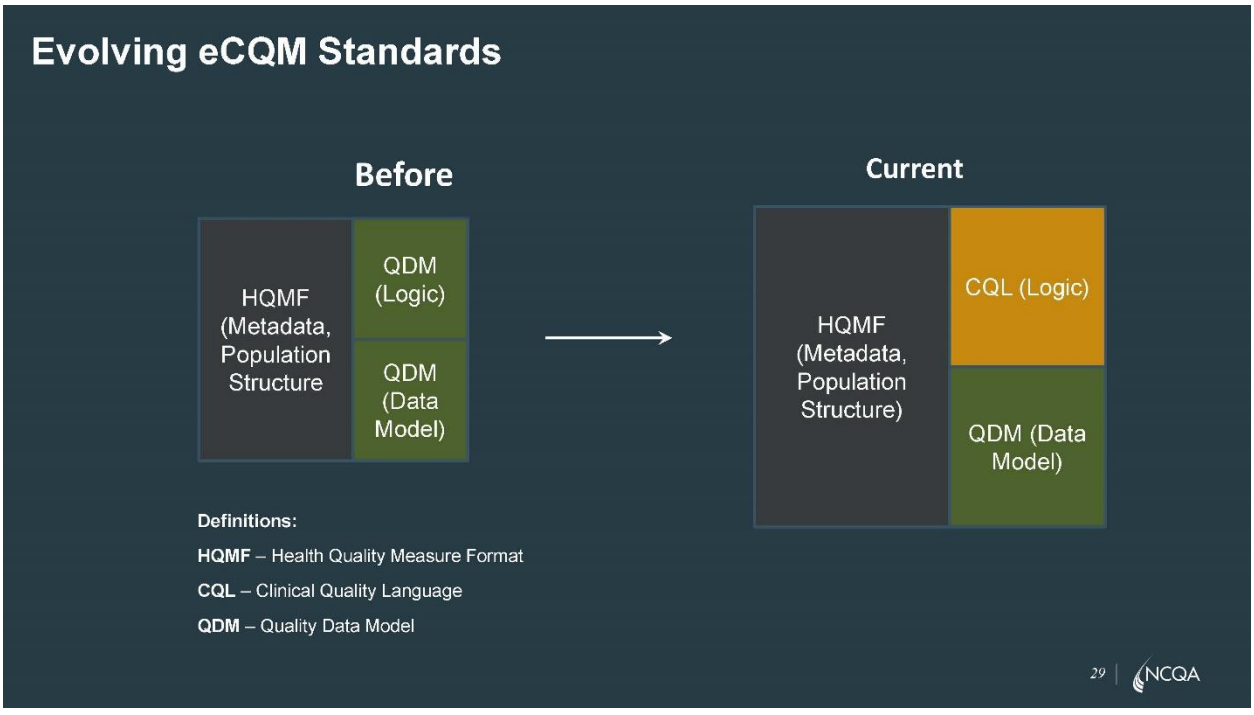
error and non-standardization in the way that the specifications are interpreted.

Anne Marie Smith: 22:32

Our digital measures are following an industry standard. HEDIS is going to be easier to implement across the continuum of care. This means we can have consistency between the providers measuring themselves and making sure they're using the same clinical constructs that we're using when we report HEDIS at the health plan level.

Anne Marie Smith: 22:54

And we're also aligning with other industry standards. When we switched to using Clinical Quality Language as a standard for digital measures, it was designed to align with things like clinical decision support. So now, clinical decision support can start talking the same language as clinical quality measures. This means that as a physician or down at the provider level, you can have your clinical decision support actually matching with the quality measure, so that if my quality measure says some service has to happen in the 27 months prior to the end of the measurement year, your clinical decision support can match that time frame and match that logic, and be able to send out an alert or a reminder that a particular patient needs a particular service.



Anne Marie Smith: 23:53

I'm going to go back to answer a question; a question probably on your mind. Why are we doing this now? It's the same kind of question that Peggy asked at the beginning. Why now? Well, one of the reasons is that the standards have now evolved far enough for us to be able to code the HEDIS measures within

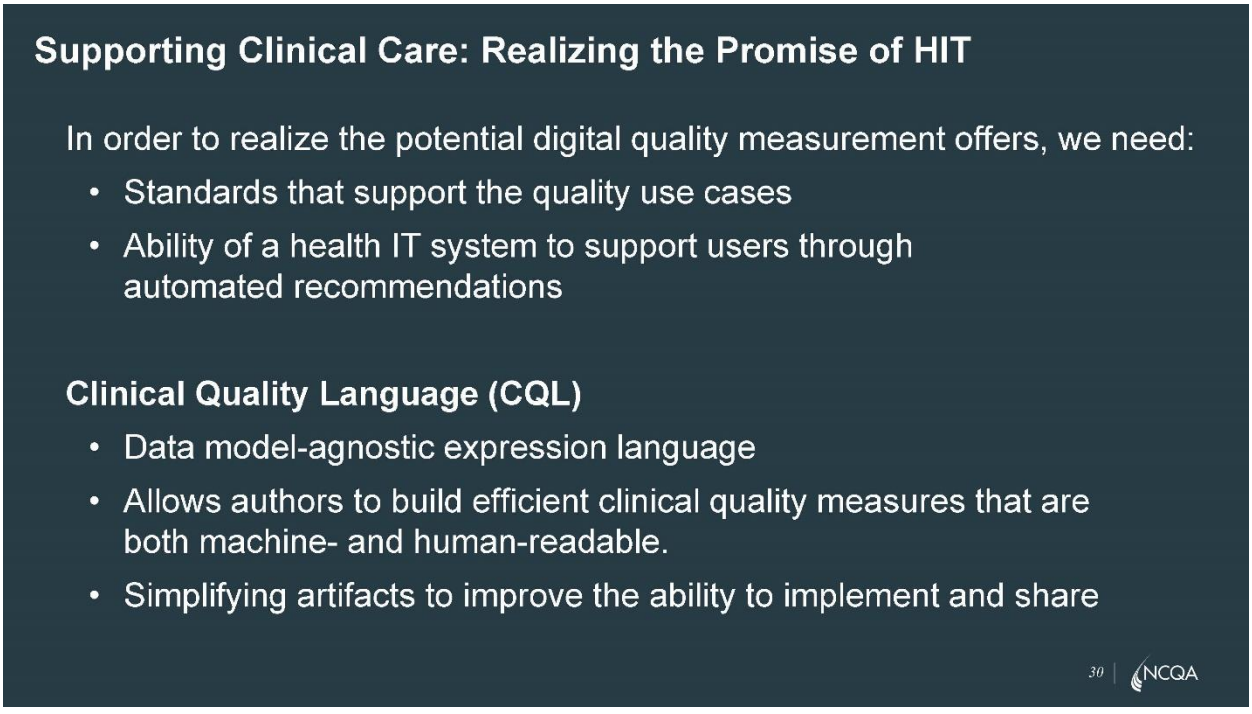
these standards. Prior to this, the standard for clinical quality measures was to use QDM as both a logic and a data model.

Anne Marie Smith: 24:28 And that had some limitations. The QDM logic really didn't allow us to express complicated concepts. For instance, continuous enrollment is a very complicated concept. It is one of the most complicated ones to express within a digital package. And we were just not able to do that before. The logic provided within QDM did not allow us to tailor that concept within the digital measure for it to be able to calculate correctly.

Anne Marie Smith: 25:01 So now, we are moving to CQL. The industry is moving to CQL. And like I said, one of the big benefits of this is the people who work on the standards, both for clinical decision support and for quality measurement, got together to design this new language. And because it needed to have components in it for clinical decision support, they had to make the logic more robust, because people had to be able to send out those reminders and alerts that physicians rely on within their EHR.

Anne Marie Smith: 25:34 So because of that, the logic is much more robust. And now we can start to express some of the things—more complicated concepts—that are in the HEDIS measures, like continuous enrollment. So, you will see those concepts expressed within our digital measure packages.

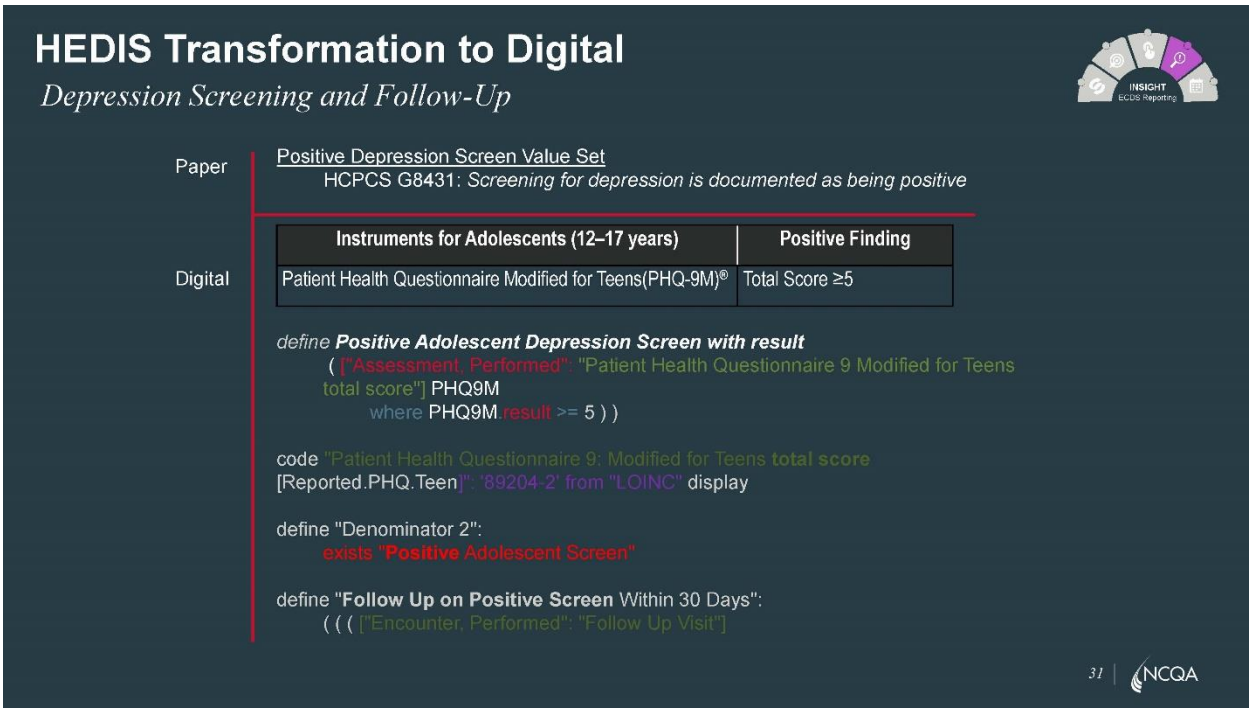
Anne Marie Smith: 25:53 Hopefully that gives you a flavor for what a digital measure package is. And now I'm going to turn it over to Ben Hamlin, to talk a little bit about what ECDS is. Ben?



412 Ben Hamlin: 26:08 Thank you, Anne. So, I think, as you heard, now is the time in which we're making these great transitions. The measures are
414 speaking the same language. However, for us to be able to really leverage the technology and leverage all this data we need to
416 shift the way we think about quality measurement. And that's what ECDS is really designed to do.

418 Ben Hamlin: 26:33 And so we can generate this knowledge very efficiently and very accurately using digital measure specifications. However, if
420 those measure specifications are designed to look retrospectively, or behind you, over a period to understand what
422 the quality use case is vs. prospectively as a decision support tool, that's not going to help you make that transition fully to
424 realize the promise of HIT that we keep talking about.

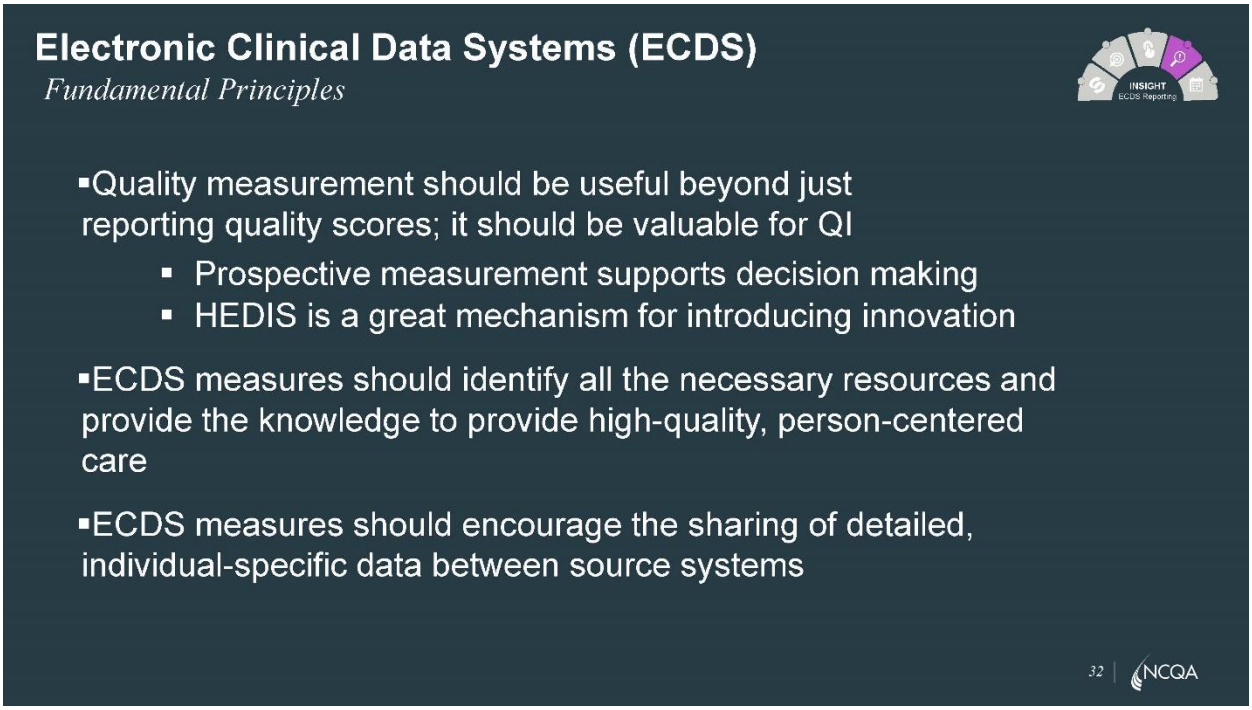
Ben Hamlin: 27:01 CQL, as Anne was mentioning, is an international standard. It is
426 a very useful language; it is a query language. And so, it fits very nicely into both quality measurement formats, but also for
428 decision support. It's also a very flexible and extensible language and it really allows us to build very complex measures, very
430 complex algorithms to generate this knowledge that we want, to understand the quality of care being delivered.



432

Ben Hamlin: 27:35 Now we get to ECDS. What this means is that we can now take
434 measures down to a very person-specific level. No longer are we producing generic concepts that we expect the frontline clinicians
436 to attest to in order to tell us whether they're doing the services that the measure says they need to.

438	Ben Hamlin:	27:58	In this example, you'll see for our Depression Screening and Follow-Up measure, which is a relatively new HEDIS measure, the paper version of this measure would use a generic G-code to say, "Yes, screening was done and it was positive. Therefore, I am meeting the measure criteria." The digital version of this measure that is now ECDS takes that five steps further. First, it defines each individual screening instrument with its own unique code. And not only does it define that instrument, but what it defines is the total score for that instrument as a unique code.
448	Ben Hamlin:	28:36	In the example you're seeing here, which is one I believe of 24 different screening instruments that are in this measure, you can see where there's a lot of work scrambling to get the instruments sorted out. The measure looks for whether this particular PHQ-9, modified for teens, was performed. It must look for the result of that screening. The score is very important in digital ECDS because the measure wants to know what that score is, because if that score is above a certain threshold, the measure puts you into the denominator of the follow-up screening component automatically, because it identified you as having a positive screen.
458	Ben Hamlin:	29:16	Now, the measure is doing all this for you now, as opposed to before, where a person at the frontline would have to be doing this to map the data over from the record to this construct. This is where we can get to a very person-specific level of information collection, around a person's unique circumstance. So, whichever tool they were screened with will count towards the measure; if we know that it's a valid instrument and there's a score in the record, we can use that information automatically in these measures.

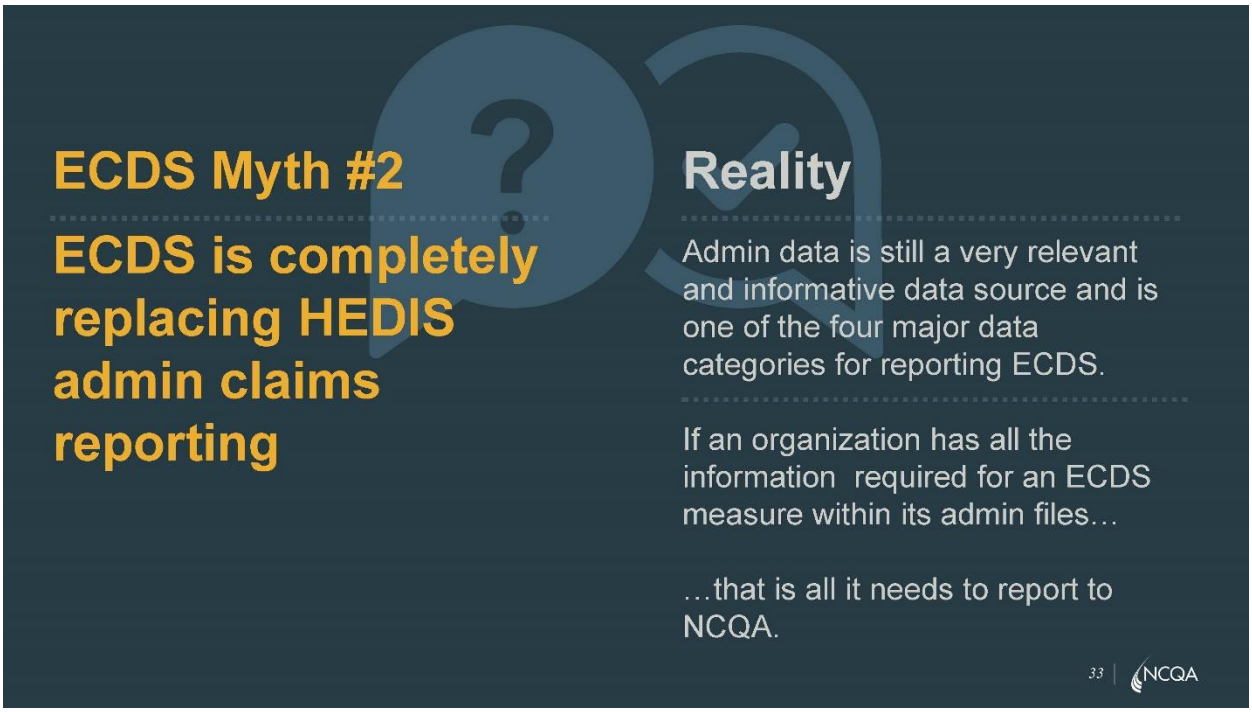


468	Ben Hamlin:	29:44	But that's just a taste of what ECDS is evolving into. And really what we did—and this started several years ago... It's been a long process of getting us to where this is: We really thought about the current environment of quality measurement. We thought about the way measures were being attacked and all the complaints, the problems, the issues with quality measurement and the quality measurement programs, whether it was CMS MIPS, whether it was CDS, whether it was all these HDO programs, everything... Everyone that was trying to do quality measurement.
478	Ben Hamlin:	30:16	And so, we sort of built a new paradigm for how to do quality measurement that does require some new quality measures. But it's more than just the measure specification itself. The idea was really to develop a measurement program that has much more value to it than just for that measurement program.
484	Ben Hamlin:	30:39	As you're collecting this measurement data, that really should be useful for quality improvement activities; it should be useful for gap analysis; it should be used for patient or provider outreach. The investments made into collecting the data or the HEDIS measure is a goldmine for other things. But right now, because it's so retrospective and it's so after the fact because of the processes used to collect this information, it's hard to realize any of that value.
492	Ben Hamlin:	31:09	And so, what we're trying to do is create measures that leverage a lot of clinical data that is acknowledged [to be] hard to access, but again, there have been many advances in that as well over

the years. There is this idea that the information should be presented when it's useful and timely, that can help drive quality improvement, as opposed to just quality reporting.

Ben Hamlin: 31:33 And so, we've sort of built these measures and this program around these principles to really reduce the burden of measurement overall. Not by reducing the number of measures, but by reducing the processes you must do to measure something or someone. And again, because they require more data, we're looking for the measures themselves to help share information that's needed across the care continuum.

Ben Hamlin: 31:57 The measures themselves don't encourage this sharing, but the program does. And so, some of the requirements of the program look for ways that the measure use cases can help encourage the interoperability of the critical data to meet that measure requirement. That is not just the payers extracting data from the vendor or from the providers, but the providers being able to access that data as well— again, creating this continuous loop of information that's used for quality measurement and quality improvement.

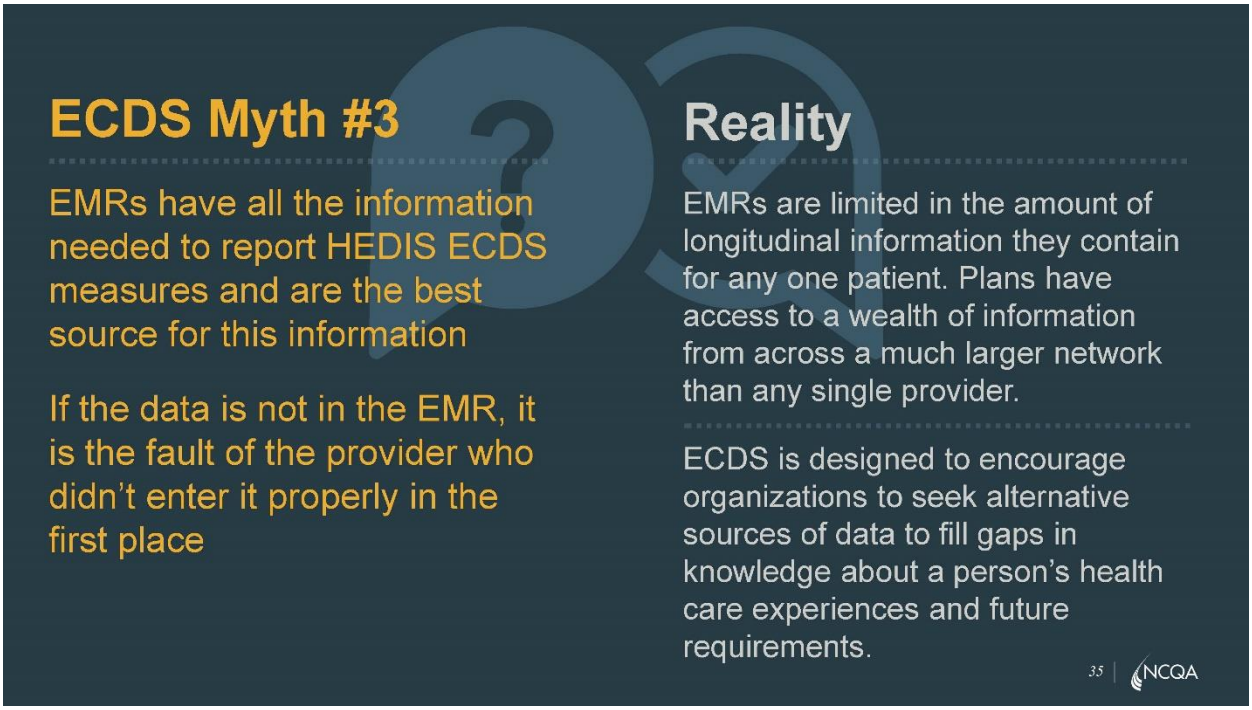


Ben Hamlin: 32:26 This is another myth. And these myths sort of bubbled to the surface of the kind of feedback we've been receiving or the kind of misconceptions that we've been hearing in the field as we've been promoting ECDS and releasing new measures. ECDS is a part of HEDIS; it is a new way of doing measurement. It is not, however, a wholly new way of doing measurements. We are not going to swap ECDS out for admin specifications in HEDIS.

522	Ben Hamlin:	32:52	Most of the ECDS architecture was constructed off the existing HEDIS architecture because this has been around, it's been validated, it works. It has been working and it continues to work.
524			It's still very meaningful and it provides a lot of useful information.
526	Ben Hamlin:	33:07	What we did was deconstruct it a bit and reconstruct it again, but that has left people a little confused, and then [saying], "Where
528			do you use my admin data?" And admin data is still extremely important in ECDS. We know from our field-testing and from our
530			first years of reporting that administrative data is the first source for most of the payers, because it's their most readily available
532			source.
	Ben Hamlin:	33:29	What you need to do is then build off that and then look to the
534			other major data source categories to backfill in the missing information. You don't have to have only admin data or only EHR
536			data, but you can have part of it fulfilled through admin and part of it fulfilled through other. Right? And so, what we're trying to do
538			is encourage looking for the data that you need, to help understand the quality of care that your members are getting or
540			that your members need, and so on and so forth.
	Ben Hamlin:	33:56	However, if for a specific ECDS measure—using an example of
542			an immunization measure—if that organization that wants to report that measure has all the information on their members
544			within their admin files, you can report an admin rate for ECDS into NCQA, and that meets all our requirements.

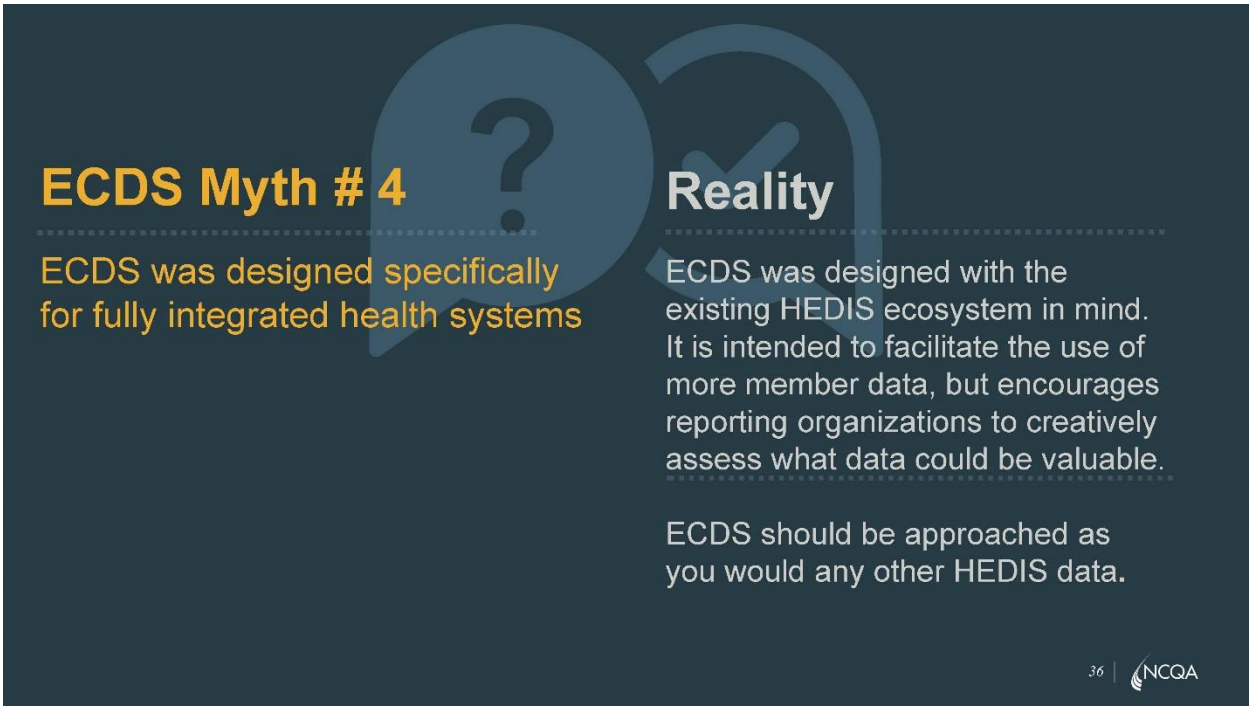
546

548	Ben Hamlin:	34:18	I like to call ECDS the next generation of quality measurement, because I'm a bit of a Star Wars and Star Trek fan, and really what we're trying to do is really think about, again, a different way of doing quality, but not dumping everything that we already know. Our idea is to get to a person-specific definition in a quality measure that is unique to a person—[an] individual person—but maintaining that core clinical component of the measure that's based on evidence-based medicine, that's going to inform whether that person is getting quality care or helping those decisions for the care team or for that patient seeking the care that they need, based on that evidence base. Right?
558	Ben Hamlin:	34:58	The measures themselves in the program are more of a compass that's kind of shifting the quality ecosystem to think more about how we get to this ideal where everyone's got their little Tricorder and you can understand exactly what they need by scanning it across their chest or their head. You know we're not there yet. I acknowledge that this is a future state, but the measures are helping us get to that state, where we are now at a person-specific level of measurement.
566	Ben Hamlin:	35:24	We are hoping to get to a person-centered focus of measurement, where all those unique circumstances for that person inform the kind of care they need. And they don't get excluded because they just have one variable that may just confound our measure calculation. It really is more about generating that knowledge that can be used for measurement, but also for quality improvement or for health care quality assessment.
574	Ben Hamlin:	35:45	And so, in this technology generation, we want these measures to do this very efficiently and quickly, but also very accurately, because we don't want the measures themselves to be driving adverse effects on the care processes. It's a delicate balance, but again, the environment is shifting and we're trying to help encourage that shift by using these kinds of measures and these kinds of reporting strategies.



582 Ben Hamlin: 36:10 Another frequent misconception we hear about ECDS is that
584 EMRs are the golden source of information for ECDS measures
and the data is all there and the data just needs to be extracted.
586 And if the data is not there it's the frontline care providers who
aren't entering it properly; and therefore, we can't extract the
588 data; and therefore, they've got to solve all their problems to help
us get this information. And it really is not true.

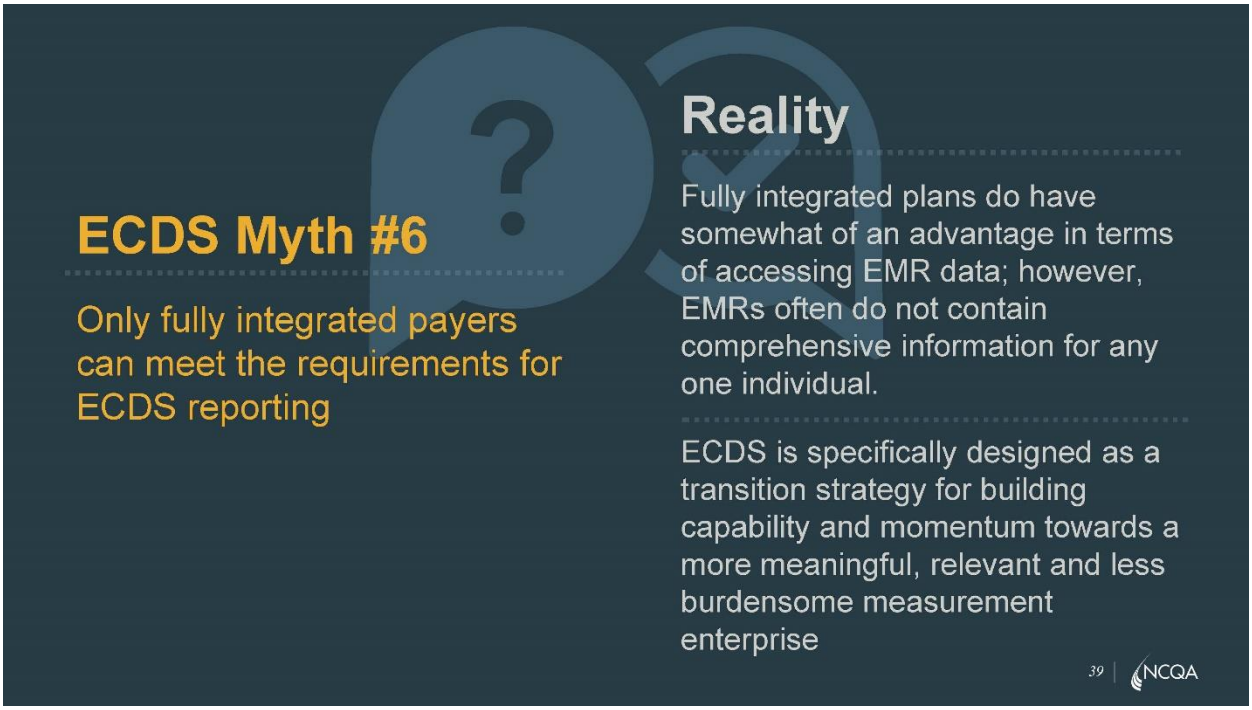
Ben Hamlin: 36:35 EMRs are a very good source of information for clinical data,
590 because it is where the data is collected at the point of care.
However, given the nature of health care in this day and age,
592 people see multiple providers. EMRs between those providers
don't often talk to each other. Where that information is residing,
594 you can't just look in one place anymore. You must look in
different places to fill that picture, if you will, of a patient's
596 experiences. Members travel across state lines; they travel all
over the place to get their health care these days. It's about
598 where are your data gaps and what do you really need to know
in order to understand a person's health care experiences and
600 what their requirements are?



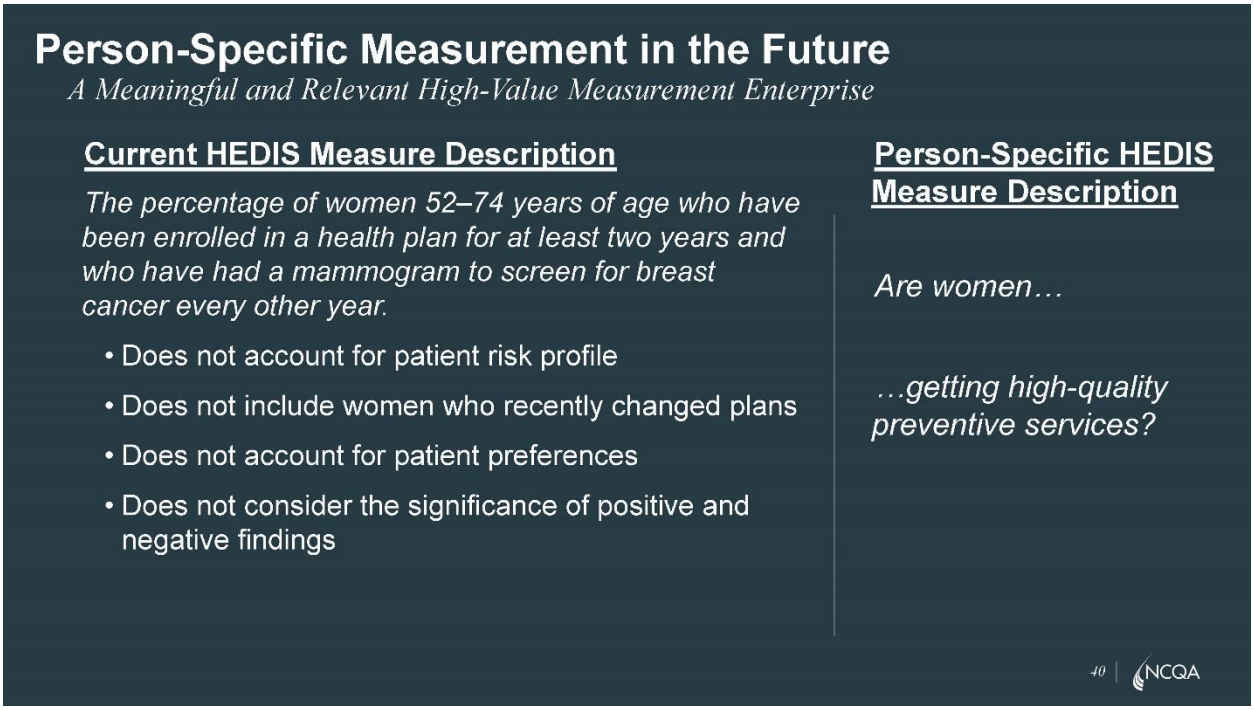
602	Ben Hamlin:	37:21	This is sort of a riff on myth #3": that we designed this program for those fully integrated health systems that have comprehensive EMR[s], are fully capitated so they know all their providers in their network, etc. That's a common criticism we hear. And really, I want to stress that ECDS is not designed for a single data source, and that we really built it off the existing HEDIS protocol. So, a lot of the things that you've done for HEDIS are very applicable to ECDS. We've just reconfigured them a little bit and reorganized the architecture a little bit to help us get to those kinds of measures of the future that we want.
612	Ben Hamlin:	38:01	And remember that one source of information is not going to be sufficient to get to the member-level of information we need for the future. You need to think creatively about how to fill those information gaps, whether it's accessing public health data, whether it's accessing employer data, and so on and so forth.
618	Ben Hamlin:	38:20	It was really designed to be this comprehensive ecosystem for digital quality improvement. And with that comes along a lot of sort-of-new things that you must do.

Ben Hamlin:	38:32	This is one of my favorites: that people still are kind of reluctant to jump into this arena. They still think it's a fad. And really, we must think about the fact that we live in a digital world. We are on a digital WebEx right now. Pretty much everybody, in every country, at almost every socioeconomic status level, has a cellphone. There's, Twitter, Instagram, Facebook. We use email every day; we use Skype communications. The digital reality is here. Right?
Ben Hamlin:	39:05	Health care falls behind in that curve a little bit in terms of the adoption of innovative and useful technology to facilitate care, because of some of the issues there. And quality measurement is pretty much where health care is. And so, again, we must really rethink what we're doing. But we must realize that digital quality measurement and digital quality improvement, if you will, is the new normal. It is today, it is happening now and it is not an unachievable barrier that you need to get to.
Ben Hamlin:	39:39	Thinking about [it], this is what you do today, this is what I'm doing now, and there we go.

640 To highlight that point, the first ECDS digital measure is going to public status in 2021. We have a very rigorous process for
642 evaluating measure performance before we put it out in the public domain, and I am very pleased to say that this measure
644 has reached that status and will be in the public domain, which leaves it open to a lot of new opportunities to use a very
646 meaningful ECDS measure for lots of quality reporting in the future.

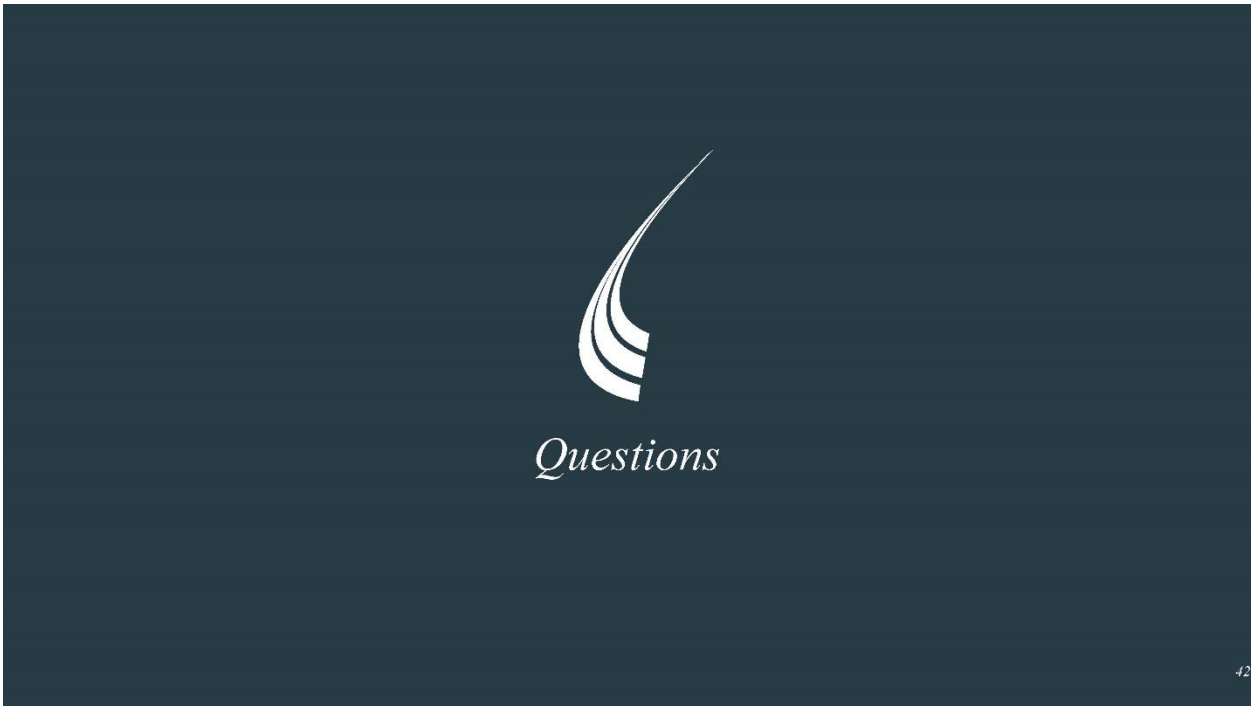


Ben Hamlin:	40:16	And finally, my last myth is: Only the fully integrated can do any of the requirements for this. And it's not about that. It really is about the fact that individual instances of EMR are useful, but they're not the sole source. You really must think beyond that. The program itself was designed as a transition strategy. It's like a compass pointing us towards a more meaningful, less burdensome, more informative measurement enterprise.



Ben Hamlin:	40:42	I'm going to give a quick example here before we go into Q&A, to walk you through what this really means. On the left of your screen is an example of a current HEDIS measure definition. Ignore the bullets below that, because this really is just what the measure does today. It's a population-level measure for a very specific cohort of women.
Ben Hamlin:	41:02	The measure does not consider any of these things below it. It does not account for the patient risk. It does not account for patient preferences. It doesn't do anything with the significance of the finding from that screening procedure. A positive observation from a mammography screening is very important in that person's health care experience.
Ben Hamlin:	41:23	And so the measure should step it up and do something with that information. We're trying to figure out how to transition the current measures that have been based essentially in paid claims, to this new environment that's very person-specific. And that person-specific definition really should be, are women getting high-quality preventive services? Are they getting what they need? And what do they need, if they're not? And that's really what we see the measure doing to help inform that, because again, they're all based on evidence. They're all validated algorithms of calculating the different components. That's a kind of common core.

Ben Hamlin:	41:58	We're doing this in a much more interactive way. We're doing this in a much more collaborative way in terms of how we're trying to develop these new strategies, because technology advances so quickly; measures don't. And for us to be able to release a relevant product in this domain, we must work intimately with our stakeholders, and even some new ones. And so, we're going to be launching a new platform, hopefully early next year, that will allow us to host discussion forums, will allow us to provide content, will allow us to understand…
Ben Hamlin:	42:34	Well, the reason we're hosting this Digital Measurement Community is just to allow us to understand where the challenges lie, that we might be able to actually adjust our strategy or produce additional resources to help [organizations] get past that so they can get into this new ecosystem very quickly and very efficiently without upending their business too much. We're hoping this is going to be a great community. It's going to be open to everyone, and so I encourage you to go sign up. And as soon as the platform is live, we will be sending out notices and starting with the content and the information flow.



	Ben Hamlin:	43:02	And with that, I'll turn it back over to Andy for questions.
	Andy Reynolds:	43:06	Hi, everyone. This is Andy Reynolds. I'm Assistant Vice President for External Relations. I'm here in Washington with Peggy and Michael. I wonder first, when it comes to answering your chat Q&A questions, I'd like to ask our colleague Brandon at WebEx to go back to slide 9, because many questions have essentially been, "When or where can we get the slides?"

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710	Andy Reynolds:	43:28	As Peggy mentioned, the materials from this webinar and even the earlier webinars in this series are all available at ncqa.org/thefutureofhedis. This slide deck that Michael and Peggy and Anne and Ben have gone through today—that deck will be there soon. As soon as we get the recording of this event from WebEx, we will post the recording. We will then transcribe the recording. So, whether you like to read or listen or watch, you'll have many ways to get today's program.
718	Andy Reynolds:	44:01	Please do continue to send your questions in the chat and we'll dive in with that. Please restate, Anne and Ben, what is the definition of ECDS and what kind of data count for ECDS?
720	Ben Hamlin:	44:15	(laughs) So, ECDS stands for Electronic Clinical Data Systems. It is the name for the HEDIS reporting program that uses measures that expect, if you will, data to come from a multitude of sources. Because there's so many different possibilities for data to come from that inform us, we've categorized ECDS data into four data categories, and that's how the measures, the data is reported to us.
728	Ben Hamlin:	44:43	The four categories are EHR, registry or HIE, case management and administrative. The different types of data kind of fold into one of those four categories in such a way that we can work to understand whether the data is being standardized and how it's being used, so that we can feed it into the HEDIS warehouse or the HEDIS measure report as soon as possible. And some of it may come directly from the EHR; some may have to pass through a registry first before it gets used. We're trying to

736			understand how the plans are accessing—or what the plans are accessing—to fulfill each measure report.
738	Ben Hamlin:	45:21	As you've been doing with supplemental data for many years and for your HEDIS report[ing], a lot of different data could be useful for those. We're just trying to categorize it a little bit so we
740			can understand the plan profile for each use report, for each measure of data source access. And that's kind of why that
742			construct exists.
744	Andy Reynolds:	45:43	Next question says, "Please say more about the data model and data source. For example, do digital measures use claims data?"
746	Anne Marie Smith:	46:00	The measures are agnostic. The format of the measure is a digital measure, but the data source can be any data source.
748			There are ECDS measures that are written in the digital format. And you can calculate those with any of the sources that Ben
750			described, either EHR data or claims data or any of the other supplemental data you're getting in for HEDIS registry data.
752	Anne Marie Smith:	46:34	So, the data source is not important. The measure is really written agnostic for the data source. If the data coming into the
754			measure meets the criteria for the measure so that the services are happening in, in the correct time frame, any of the data can be used to calculate the measure.
756	Andy Reynolds:	46:54	We have several questions about the development time frame.
758			One such question says, "How do you envision [that] the timeline to actually produce HEDIS results will evolve as we adopt more digital or standard methodologies for calculations?"
760	Ben Hamlin:	47:09	Hopefully it'll be much faster. You know, as with research and these large clinical data sets, where you can run the very
762			complicated questions through a large clinical data set and return answers very quickly, we're hoping that that will not only
764			affect the way that clinical guidelines are developed, which most of the measures are built from, but also it'll enable us to do
766			feasibility and usability assessments of clinical data. Whether it's from a planned perspective or whether it's from an HIE
768			perspective, in order to understand whether what we're specifying as a digital measure will even work, whether it's now
770			or quickly in the future, or there's just no hope.
772	Ben Hamlin:	47:49	By being able to facilitate that information-gathering from months down to weeks, and almost [from] years down to weeks; that's
774			really going to help us advance this idea of these more complicated measures that need more specific data. We first
776			need to know, when we develop a measure, what the clinical guideline says. But then we need to know what the data looks
778			like out in the real world. So, can we translate that clinical guideline into a quality measure?

780	Michael Barr:	48:15	This is Michael. There's one other dynamic to each of those questions I want to address. And that was the separation of the first batch of digital measures in July of this year from the ones we're releasing tomorrow. That's not our intent, going forward. The intent is [that] the measures will be released on the regular HEDIS timeline that I illustrated earlier.
786	Andy Reynolds:	48:40	Who is responsible for writing CQL code? Does the NCQA certified software vendor do that?
788	Anne Marie Smith:	48:50	I'm going to tie that in with another answer, Andy, as well. The digital measure packages come with the CQL code written in them. So, we are producing the measures in the CQL language with the QDM as the data model. And then we are generating those packages. And I want to tie into it, because it seems the natural thing, like, "What is it? Why do I call it a package?" What happens is, you will get a zipped folder when you get a package for a digital measure. And it will have the human readable portion in it, written in CQL QDM.
796	Anne Marie Smith:	49:28	It will also have three other files in there. One of those will be an XML file, and that will be an ELM file, an Expression Logical Model. And I'm going to really geek out here now, so if only half of you understand this, that's fine. ELM is a machine-friendly syntax independent canonical representation of the CQL. So—
	Peggy O'Kane:	49:53	I'm having a seizure [crosstalk 00:49:56] (laughing).
802	Anne Marie Smith:	50:00	So, for those of you who that made no sense for, hear "machine-friendly rendering of the CQL logic." (laughs). All right? And this is intended to be the mechanism for distribution of these libraries.
806	Anne Marie Smith:	50:15	What happens is [that] in your implementation environment, you can either directly execute the ELM or you can take and translate that ELM into your target environment language, like SQL or Java. Okay? So, that answered probably about three questions out there (laughs).
	Peggy O'Kane:	50:33	It probably raised about 12 more (laughs).
812	Anne Marie Smith:	50:35	And I'm sorry for giving you seizures (laughs).
814	Andy Reynolds:	50:38	Here is another three-in-one question: How do ECDS measures relate to other quality programs like Health Plan Accreditation, NCQA Health Plan Ratings and Star Ratings at CMS?
816	Ben Hamlin:	50:57	When I mentioned that the new PRS measure is going to be publicly reported in 2021, that is the first step in our ability to use that measure for any of those programs or for any kind of public reporting status. The measures that are used for rankings, etc.,

820			must achieve that public reporting status first. That's the first piece of that question.
822	Ben Hamlin:	51:23	For measures that are in the public reporting status, to get used for Accreditation scoring, [organizations] must go through a whole process of our Accreditation review, in which measures are used for that scoring process. And that's a whole separate process that's done by the Accred folks.
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	Ben Hamlin:	51:37	But they're only allowed to select the measures that are available in the public domain. So, the measures must go through the first step of getting to the public domain, the second step of getting reviewed for the different programs; and whether they get picked up by those programs is dependent upon [an] additional set of discussions and approvals; processes that happen after the measure is available.
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834	Peggy O'Kane:	51:55	And if I'm hearing some anxiety behind that question, we would be very careful not to include an Accreditation measure that large numbers of clients couldn't report. We're trying to manage the change here in a way that makes it possible for all of us to succeed. And there was a question about Stars. We develop a lot of the Stars measures for CMS and we work very closely with CMS. Are we changing any Stars metrics right now? You know, that will be another threshold to cross, I think.
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842	Andy Reynolds:	52:37	We have five minutes more scheduled for this program. I see a way to knock out two quick ones. I'd like to ask Brandon, our colleague at WebEx, please advance to slide 21. While you do that, I'll ask another question: Will all HEDIS measures eventually be written in the digital format? Is that the future?
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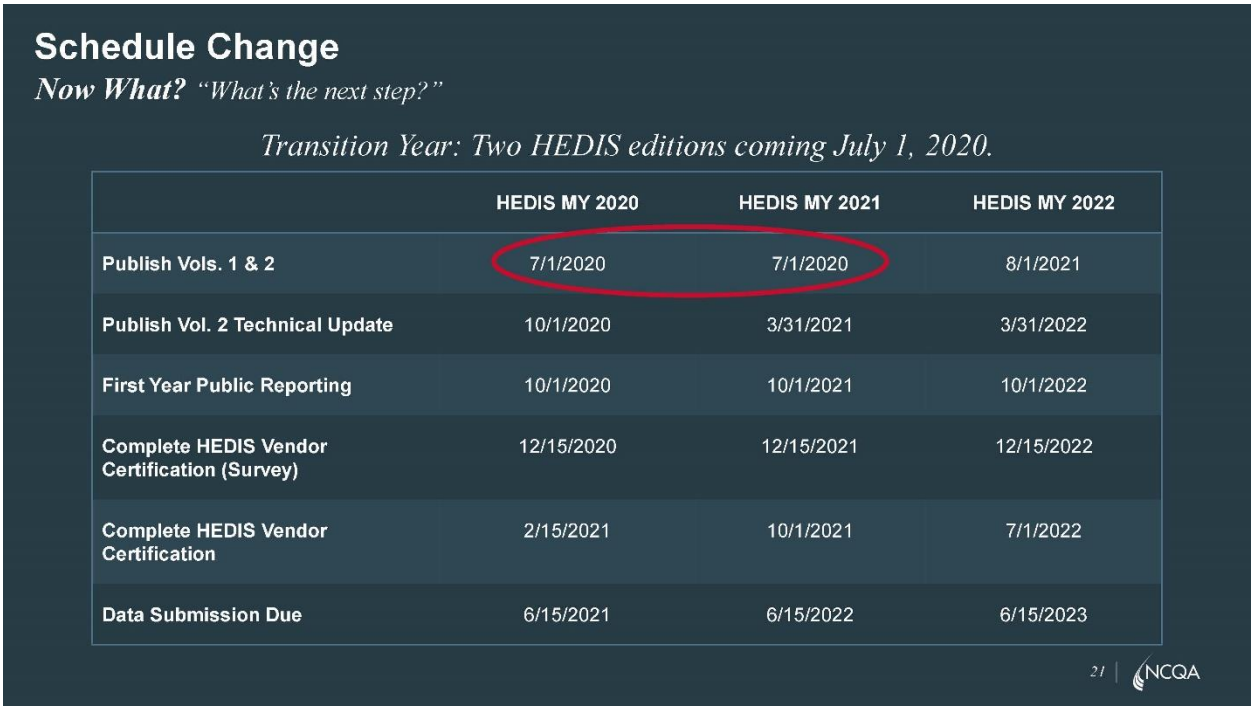

Schedule Change

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

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

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

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848	Michael Barr:	53:01	This is Michael. I think the answer is likely that not all the measures will be digitalized, because some of them will be difficult to digitalize. We're working through a prioritization scale to digitize those existing measures in the traditional reporting that could be, and then should be, translated to digitalized format. I'm going to ask the team if they have any other perspectives on that.
856	Anne Marie Smith:	53:27	Right. And I would just say that a good example of measures that are hard to digitize are the risk adjusted measures. So, we've given more thought and care to, "Can we do that? Is that the right thing to do?"
860	Andy Reynolds:	53:44	Here's the question that explains why this table is useful. The new specs released in July 2020 are for measure year 2020 and measure year 2021. Will the specs for both measure year 2020 and 2021 be the same?
864	Suzanne:	54:01	This is Suzanne, from NCQA. At a minimum, the measurement year will change and [it is] likely [that] value sets will change between the two publications. And as you can tell from that slide, each of those publications will have a technical update. So, there might be changes to measures that we might not have captured between the 10/01/2020 technical update and the 3/31/2021 technical update. So, we're trying to limit how many changes there are, but there will be some.

872	Andy Reynolds:	54:36	As more digital measures come online, when will traditional HEDIS measures be retired? Will the schedule of retirement change?
874	Michael Barr:	54:44	I think the process for reviewing measures for retirement will continue as it is. We'll continue to look at the portfolio to see which measures are topped out [crosstalk 00:54:59]. Yeah, I think as we digitalize, are we also looking to retire? That was the question.
880	Peggy O'Kane:	55:07	Well, no... I think the question was about, are you going to make us go onto the new platform or can we continue reporting in the older way?
882	Peggy O'Kane:	55:19	Yeah, well, we're going to see how it goes. I mean, if we have a lot of people that can't report in the new way, then we will have to continue with both ways, which of course is not easy. So, we're hopeful that the pace of change on the outside that will enable us to have a reasonable pace of change will be sufficient, but we're dependent, as you are, on forces beyond our control about that.
890	Michael Barr:	55:47	And actually that reminds me, we did not call out 3 measures that are in the 11 ECDS measurement portfolio, that are also specified in the Volume 2 PDF, so that if you want to see what your rates will be like reporting on the same measure in the two different ways, there's Breast Cancer, Breast Cancer Screening, Colorectal Cancer Screening and an ADHD Follow-Up for Adolescents. Those are a few measures [for which] there's an ECDS specification, and of course the original HEDIS specification.
898	Michael Barr:	56:18	Back on the retirement, and I apologize if I misunderstood the question, but since I started to answer it, let me just finish. We will continue to look at the HEDIS portfolio, as we always have, to see which measures are ready for retirement. And that will proceed on the same pace as it has before, and we'll keep looking for opportunities to reduce the measurement burden.
904	Andy Reynolds:	56:39	I think we have time for one more question, so let it be this: Can you speak to specific changes you've made with ECDS measures to make them more prospective? In other words, what makes ECDS prospective?
908	Ben Hamlin:	56:54	That's not a great question to do in one minute. But (laughing), it's this idea that the way you look for the services, the way you identify the different data elements and the definitions around those... it's about the measure specifications. For example, how are you calculating the data? If you're doing it prospectively, you are kind of doing it in a very linear fashion, because you're just scanning to look for specific aspects to be called out by the measure. You're not doing it based on the measure calculation itself. You're doing it based on the person.

918	Ben Hamlin:	57:28	As an example, for a depression screening, you'd first look to see if a screening was performed. Then you look to see what the screening score was. Then you look to see if that screening score was positive or negative. Then you look to see if the positive indicates the person needs additional follow-up. That's all done by the measure calculation.
924	Ben Hamlin:	57:46	In a different example, for a traditional HEDIS measure—let's say, breast cancer—if you identify whether the person is [a] female of a certain age, you then see whether they've had a mammography in the last two years based on the measure calculation. You then look to see if there are exclusions for that measure. Have they had some kind of breast surgery or not?
930	Ben Hamlin:	58:08	It's a sort of backwards way of looking at the information. We're really trying to specify the measures to be much more decision-support oriented in the clinical flow of how a decision-support tool might work, as opposed to how you might manipulate data to calculate a measure score. [crosstalk 00:58:25]-
934	Peggy O'Kane:	58:24	I mean, I think what you're saying, Ben, is that the use of the measure can be more prospective—
936	Peggy O'Kane:	58:32	... but the actual accountability is still in the retrospective.
	Ben Hamlin:	58:34	Sure, because it works both ways. I mean, you can look ahead—
938	Ben Hamlin:	58:38	... to see what the person needs or what data gaps there are [crosstalk 00:58:40]. But you can also push a button and generate a report that shows you what's happened-
	Peggy O'Kane:	58:47	Yeah.
942	Ben Hamlin:	58:48	... based on those same criteria.

944	Peggy O'Kane:	58:48	Yep. Well, thank you, all. Thank you for your great questions. And we look forward to further dialogue with you. Thank you so much for your attention. And we hope we can get past the fear point to the excitement that I think this project will generate in all of us. At least, that's my hope. So, thank you.
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	Brandon:	59:13	The slides and a recording of [the] webinar will be available on the NCQA website next week. We'll be offering webinars on this topic in the future, so check back. Ladies and gentlemen, that will conclude today's event. You may now disconnect your lines. Thank you.
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