# Health IT Policy Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

October 14, 2014

Karen DeSalvo, MD, MPH, MSc
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
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Dear Dr. DeSalvo,

The Health IT (HIT) Policy Committee (HITPC) gave the following broad charge to the Accountable Care Workgroup (ACWG):

**Charge for the Accountable Care Workgroup**

Provide a set of recommendations to the HITPC regarding how ONC and HHS can advance priority health IT capabilities in a variety of accountable care arrangements to support improvements in care and health while reducing costs.

**Background**

The ACWG was formed in 2013 to develop a set of recommendations in accordance with the charge above. The ACWG undertook an extensive deliberation process focused on reviewing core health IT capabilities to support providers operating under accountable care arrangements, identifying the most high priority capabilities, and considering actionable steps to advance these capabilities. In December 2013, the ACWG conducted a day-long in-person hearing with representatives of physician-led and health-system based ACOs, representatives of communities oriented accountable care models, and representatives of technology vendors serving providers working in accountable care arrangements.

The ACWG presented a report-out on this hearing to the HITPC in January 2014. In April 2014, the ACWG presented a set of draft recommendations to the committee for their input and comment. After making a series of revisions, the ACWG presented a set of final recommendations to the committee for their approval during the July 2014 HITPC meeting. The HITPC requested several changes to these recommendations prior to approval, and the revised recommendations were circulated for virtual approval by the committee. The recommendations were finalized on September 12, 2014.

**Introduction**

Thirteen years ago the Institute of Medicine published *Crossing the Quality Chasm: A New Health System for the 21st Century*[1] which articulated redesign imperatives for the health care delivery system. Among the rules for redesign the committee set forth was "knowledge is shared and information flows freely and cooperation among clinicians is a priority. Since that seminal work was published, much has changed in the U.S. health care delivery system. Legislative reforms such as HITECH and PPACA and the regulatory efforts that followed have generally focused policy upon the challenges set forth in the IOM document, including *reengineered care processes, effective use of information technologies, knowledge and skills management, development of effective teams,* and *coordination of care across patient-conditions, services, and sites of care over time.* However, much of the delivery system reform is a work in progress. Care model redesign, payment system redesign, and information system redesign are occurring simultaneously, with such efforts as Meaningful Use, public and private Accountable Care Organizations, PQRS, the Pioneer Program, the Medicare Shared Savings Program, and bundled payment programs interacting as a hyper-dynamic series of forces that are accelerating health care delivery transformation.

The IOM report noted that "the importance of adequately preparing the workforce to make a smooth transition into a thoroughly revamped health care system cannot be underestimated." There is wide agreement with the IOM statement that information technology holds enormous potential for transforming the health care delivery system, but also general acceptance of the forewarning that "the challenges of applying information technology should not be underestimated." It is noteworthy that the recent Rand study[2] of physician professional satisfaction found that the electronic health record as it functions is the single greatest common factor in physician dissatisfaction across the spectrum of care settings. Also noteworthy was the acknowledgement of these same physicians that information technology holds enormous potential to improve the health care delivery system as the technology improves over time. Much of the work that is yet to be done at the policy level is tied to the imperative of enhancing processes that will enable the health care delivery system to successfully fulfill the aims of the IOM report: namely, to provide care that is effective, efficient, equitable, patient-centered, timely, and safe. This work will necessarily take into account the points-of-view of many stakeholders if it is to be successful.

One area largely absent from the IOM report is the inherent problems in the fee-for-service financial payment system, which is a powerful incentive to behavior by the participants in the health care system. The legislative priority in PPACA to create Accountable Care Organizations largely reemphasizes the importance of the payment system on the success of system reform. The unique importance of

[1] Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Retrieved from: http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

[2] Rand Corporation. (2013). *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy.* Retrieved from: http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR439/RAND_RR439.pdf

Accountable Care Organizations is their alignment for rewarding the achievement of many of the objectives of the IOM report. However, much work is necessary at the policy level to ensure that the lofty goals of system reform are implemented rationally and effectively in the day-to-day world of real health care delivery.

On April 19, 2013 the Accountable Care workgroup began work on its charge to make recommendations to the Health IT Policy Committee on how HHS policies and programs can advance the evolution of a health IT infrastructure that enables providers to improve care and population health while reducing costs in accountable care models. Through a series of meetings, a public hearing, and many hours of collaborative work addressing this charge, the committee has developed a final set of recommendations, presented to the HIT policy committee on July 8, 2014. Our work focused on the real world challenges of providers trying to make these new financial models work and represent important insights in aligning technology, financial incentives, and clinical transformation in edging us closer to the IOM idea. We are grateful for the opportunity to contribute to the efforts to improve our health care delivery system.

**Framing Statements**

The following high-level statements help to frame the Workgroup's recommendations:

- The Workgroup sought to advance a set of IT-enabled capabilities common to providers working under a wide range of accountable care arrangements, including but not limited to accountable care organizations.
- The workgroup heard from a variety of stakeholders over the course of its work, but focused most heavily on the delivery system perspective to understand the unique business and clinical requirements of providers in accountable care arrangements.
- The HIT and data infrastructure to support accountable care arrangements extends beyond the core use of EHRs for patient care, and includes information exchange, integration of data across settings, and analytics capabilities.
- Streamlining the administration of value-based programs is a crucial priority for providers engaged in accountable care models, especially across multiple payers. HHS must continue current efforts to minimize administrative burden across programs to avoid jeopardizing the ability of providers to succeed within these models.
- Investing in the robust IT infrastructure needed to support accountable care arrangements is a continuing challenge for providers, especially smaller organizations. HHS must continue to develop and expand strategies, such as the Advance Payment Model, to help providers invest in the infrastructure necessary to support accountable care models.

**Final Recommendations**

The Accountable Care Workgroup recommendations are organized across 4 focus areas:

**I. Exchanging Information across the Healthcare Community**

**II. Data Portability for Accountable Care**

III. **Clinician Use of Data and Information to Improve Care**
IV. **Leveraging Existing Sources of Information to Support Data Infrastructure for Value-Based Programs**

Each of the focus areas includes the following elements:

- *Background:* A brief statement about the rationale for why the Workgroup is focused on this topic, current challenges ACOs are experiencing in this area, and existing efforts that Workgroup recommendations seek to build on.
- *Strategy Statements:* Key overarching themes that the Workgroup would like to see guide future work in this area.
- *Actionable Recommendations:* These recommendations represent high priority opportunities to advance work in the focus area. Some represent immediate opportunities to benefit providers working in accountable care arrangements, while others are more likely to impact providers in the medium or long term but require increased attention now.

## I. Exchanging Information across the Healthcare Community

*Background*

As patients assigned to one ACO seek a significant amount of care elsewhere, providers need access to information across institutional boundaries to effectively manage patients and deliver safe, high quality care. Yet today, strategic, technical and financial considerations continue to inhibit exchange of health information in many communities. In addition to increasing exchange of information among "core" providers such as hospitals and health systems, providers in accountable arrangements must also be able to electronically exchange data across the broader continuum of care with entities such as long term care facilities, behavioral health providers, and community service providers that are crucial partners in the care of many high-cost/high-risk patients.

*Strategy Statements*

1. ONC should coordinate across HHS to define and implement quality measures and value-based payment arrangements that reflect outcomes achieved across the care continuum and encourage providers (especially hospitals and health systems) to electronically and securely share clinical information with any appropriate receiving entity to improve the quality and safety of care across settings.
2. Providers ineligible for the EHR incentive program, including LTPAC, behavioral health, and home health providers, are critical partners for ACOs but need additional support for HIT adoption.
3. Exchange of behavioral health information across providers is critical for ACOs focused on high-cost/high-risk patients and for patient safety. SAMHSA and ONC must further explore strategies to facilitate the flow of behavioral health claims data and other sensitive data that are subject to

additional privacy protections between and within ACOs and providers of mental health and substance abuse services.

*Actionable Recommendations*

a. **CMS should leverage innovative service delivery models to encourage hospitals and other institutions to make admission, discharge, and transfer (ADT) feeds available to any appropriate receiving entity across their community.** Many communities have demonstrated that electronic patient event notifications supported by ADT feeds are a powerful and low-cost tool to allow participants in value-based payment programs to better manage patient care. As CMS looks to scale many of the innovative service delivery models it has deployed, and designs forthcoming models with a medical neighborhood or community orientation, it should work with ONC to ensure these models encourage participating hospitals and health systems make ADT feeds widely available to other entities to support community wide care coordination goals.
b. **ONC should work with CMS to update hospital survey and certification standards to require institutions to make electronic discharge summaries available to external providers in a timely manner.** CMS should update hospital survey and certification guidance to state surveyors to include assessing the degree to which hospitals send electronic discharge summaries in a timely manner to the external providers of the patient's care, regardless of affiliation with the hospital.
c. **Increase public transparency around hospital and health system performance on measures related to health information exchange through public reporting Web sites.** ONC should work with CMS to explore public reporting options that would measure the degree to which hospitals and health systems are appropriately sharing health information. For example, this might be achieved through the reporting of Meaningful Use transitions of care measure results as part of inpatient quality reporting on the Hospital Compare Web site. HHS could also consider outcome measures which demonstrate that hospitals and health systems are achieving positive health outcomes that reflect effective sharing of information among providers.
d. **Explore new accountable care models that focus on achieving shared savings in accountable care organizations that feature significant participation from LTPAC, behavioral health, or home health providers.** CMS should explore accountable care models under which ACOs can receive shared savings for demonstrating improvement on measures reflecting successful coordination with entities such as LTPAC, behavioral health, and home health providers. Many of these providers were not eligible for the EHR incentive program and do not have the IT infrastructure to participate in robust care coordination initiatives; shared savings incentives from such a model could be targeted to support IT infrastructure development for these partners.
e. **Explore regulatory options and other mechanisms to encourage appropriate sharing of information protected under 42 CFR Part 2 across participants in an accountable care organization.** As SAMHSA considers options for refining rules around the sharing of information protected under 42 CFR Part 2, it should address key needs for providers participating in accountable care organizations. For instance, SAMSHA could permit ACO entities that include substance abuse facilities to establish QSOAs across participants with an administrative

relationship, or clarify the conditions under which primary care providers conducting SBIRT services are considered Part 2 providers.

## II. Data Portability for Accountable Care

*Background*

The information infrastructure needed to support multiple providers working together in accountable care arrangements must be flexible and scalable across networks and capable of: aggregating data across a wide range of systems to support a comprehensive view of the patient; delivering seamless care coordination across settings, and managing populations of attributed patients. ACOs seeking to establish platforms for population health management across multiple systems are acutely experiencing interoperability challenges, yet they often lack the leverage to drive vendors to implement solutions to these issues. Future evolution around interoperability standards, certification for electronic health records, and other policies should seek to align with the needs of organizations investing in the infrastructure and services needed to achieve success within value-based payment models.

*Strategy Statements*

1. Data residing in EHRs needs to be seamlessly available to multiple types of HIT applications, for instance, to support population health management platforms which integrate data across care different settings and systems.
2. ONC should focus additional attention on discrete data standards, in order to effectively promote data interoperability across systems, in addition to further constraining document based data standards.
3. ONC can increase vendor accountability by ensuring products not only send data, but can also receive and process data.

*Actionable Recommendations*

a. **Require certified products to allow increased access to data residing in EHRs by other types of HIT systems to support population health management, operations, financial management, and other functions.** The health IT certification program should consider a requirement by which vendors would demonstrate that they can easily integrate with other applications. For instance, ONC could implement standards being developed under the Data Access Framework (an S&I Initiative) around a common API for HIT applications which would allow real-time sharing of information between applications.
b. **Pursue greater specificity in federal interoperability standards around transactional data.** The availability of structured data is critical to accountable care infrastructure. ONC should continue to develop more specificity in federally recognized interoperability standards to promote semantic interoperability and seamless flow of information across systems. ONC should look for immediate opportunities to increase specificity around transactional data such as discrete HL7

data feeds for admissions, discharges and transfers, notifications, labs, prescriptions, etc., as well as further specification of structured data within the CCDA.

c. **Strengthen data portability elements in certification criteria to ensure systems have demonstrated that they can receive and process data, not only send data.** Lack of confidence around the ability of HIT systems to receive and process data, despite being certified to send data, is a major challenge for accountable providers seeking to coordinate care. ONC should expand testing procedures for certified EHR technology that require products to demonstrate the technical ability to not only send discrete data points in a recognized, structured, and consumable manner, but also receive and make data computable within a receiving application.

## III. Clinician Use of Data and Information to Improve Care

*Background*

Organizations operating within accountable care models require tools that support clinicians' ability to deliver effective synchronous and asynchronous care to patients and engage with other clinicians and providers across virtual, interdisciplinary care teams. While the meaningful use of EHRs provides an important foundation, providers in accountable arrangements have additional needs around advanced health IT-enabled care tools and processes to accelerate gains in quality and efficiency.

*Strategy Statements*

1. Dynamic shared care planning that supports virtual interdisciplinary care teams across the continuum of care is a critical capability for providers that are accountable for the care of attributed patients across settings.
2. A wide range of health care stakeholders beyond those who have traditionally conducted care planning need to develop consensus around workable models of care planning across organizations using standards-based tools.
3. Clinical decision support tools are a key strategy for ACOs to promote adherence to evidence based guidelines, but significant questions remain regarding their effectiveness.
4. Providers within ACOs need access to actionable measures that address both quality and cost in order to make informed decisions in the value-based care environment.

*Actionable Recommendations*

a. **Establish pilots to understand how clinicians can use electronic shared care planning tools to deliver effective team-based care across settings.** Granting agencies such as CMMI, AHRQ, HRSA, and others, should establish new initiatives to pilot, test, and document best practices for using electronic shared care planning tools including HIE-based services, EHR-based modules, and care management software.
b. **Facilitate consensus around shared approaches to standards-based electronic shared care planning across the continuum of care to promote wider adoption of these tools.** The

comprehensive, longitudinal, care plan is an integral tool for coordinating patient care, particularly within the accountable care environment where multidisciplinary care teams across settings must deliver coordinated care. While electronic standards continue to mature, a lack of broad clinical consensus around the value of care planning approaches outside of specific disciplines (e.g. nursing), and questions about how to implement shared care planning approaches in practice, will continue to result in minimal adoption of these approaches. ONC can work with other agencies across HHS to act as a neutral convener to accelerate consensus across the clinical community around a vision for interdisciplinary shared care planning. Following input from clinical stakeholders, patients, vendors, technology experts, and others, HHS could then look at how various policy levers, including the future trajectory of electronic standards for care planning tools, can be aligned with this consensus vision.

c. **Pursue research with federal partners such as AHRQ around the effectiveness of clinical decision support to improve the impact of these tools.** More research is needed into when CDS is effective in informing clinician decision-making, e.g. the breadth of data needed to deliver effective decision support. ONC should partner with AHRQ and other federal partners to better understand how human factors research and user interface design can maximize the impact of clinical decision support and potentially inform how the health IT certification program can maximize the effectiveness of CDS in the future.
d. **Explore strategies to increase the utility of CDS tools by supporting the incorporation of external data from multiple sources.** A key use case for ACOs around CDS is the ability of external data to be integrated with data in the EHR so that it can trigger a more sensitive CDS alert. More work is needed around how to get to this functionality. ONC should prioritize development and certification of standardized functionality within EHRs that would enable consumption of external data to trigger clinical decision support alerts.

## IV. Leveraging Existing Sources of Information to Support a Data Infrastructure for Value-Based Programs

*Background*

In order to succeed in value-based care models, ACOs need to bring together a number of different data sources in an integrated fashion to inform business and population health management strategies. ACOs must calculate the total cost of care on a given patient, assess the overall cost effectiveness of their care coordination and care management programming, conduct predictive modeling, run attribution algorithms, determine the costs of "keepage/leakage," and conduct financial analyses to determine how managing at-risk patients affects their overall financial health. Ultimately, ACOs need to be able to integrate this information with clinical data to fully understand how to maintain and improve quality while decreasing costs. Today, however, administrative data across payers remains inaccessible to most providers, hampering their ability to fully understand the cost of care for attributed patients, and the infrastructure for delivering this data remains nascent or inconsistent across communities.

*Strategy Statements*

1. Accountable care providers need increased access to existing administrative and encounter data that is currently inaccessible or unusable, including claims data, data from social services providers, eligibility and benefit determination data, and other sources.
2. Further understanding is needed around the scalable data architecture models that can aggregate multiple types of existing data to support the needs providers in value-based payment programs across different regions, states, and localities.
3. Public and private sector stakeholders must collaborate around key enablers of this infrastructure such as a common standardized methodology and approach to attributing patients in the ACO environment across all payers and providers.
4. HHS should continue to work towards a vision of standardizing all measures required by various agencies, departments, and programs, so that all unique and relevant measures can be calculated and submitted once by a given provider to a single location.

*Actionable Recommendations*

a. **CMS, ONC and other federal partners should work together to articulate a future strategy around how the government can advance a scalable data infrastructure model to meet the data and reporting needs of providers in accountable care arrangements.** Integrating clinical data with claims, cost, and price data across participating payers and providers can support less burdensome reporting of quality metrics, increased capacity of providers to improve quality and reduce costs, and improved specificity of predictive modeling. HHS and other federal partners can advance progress toward these objectives by articulating a strategy for how the federal government will engage with the various entities capable of receiving and aggregating these data at the local, regional, and state level (e.g., all-payer claims databases, regional health improvement collaboratives, health information exchanges, Medicare qualified entities, etc.).
b. **ONC should coordinate across HHS to expand support for the development of state-level all-payer claims databases (APCDs) to support accountable care arrangements (inclusive of Medicare & Medicaid).** CMS should use state-level mechanisms (e.g. SIM funding) to support the development of APCDs, ensure that Medicaid and private payers doing business in that state are contributing data to an all-payer claim database or other identified entity, and ensure that APCDs make data on their attributed patients available to provider groups taking on financial risk. A uniform quality assurance methodology to assess the reliability of claims integration processes should be independently developed as part of this program.
c. **Drive progress on standardization and capture of social determinants of health data elements that are critical to accountable care and other delivery models.** Healthcare stakeholders must work towards inclusion of a broader set of information of community and social inputs that are critical to effective care delivery, beyond clinical information alone. ONC should work with other HHS initiatives, such as the State Innovation Model, to understand the scope and issues related to making an integrated set of social determinants of health (SDH) available for both patient care and for planning/research purposes. ONC/HHS should build on existing efforts (e.g. current initiatives led by the Institute of Medicine) and consider establishing pilots to focus on the

capture and sharing of social determinants of health data to inform how future policy directions can support access to and availability of this data.

We appreciate the opportunity to provide these recommendations.

Sincerely,

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