Testimony of

Matt Eirich

Executive Director, New Product Development

The Advisory Board Company

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Thank you to the Health IT Policy Committee Workgroup on Accountable Care for holding today's important hearing and inviting testimony from The Advisory Board Company. My name is Matt Eirich. I'm an Executive Director in Advisory Board's New Product Development Division. In this role, I identify and develop solutions for health care providers pursuing accountable care. It is my pleasure to offer this statement on issues related to vendors' and service providers' ability to assist our care provider partners in reaching their accountable care goals.

Background

Founded in 1979, Advisory Board is a global research, technology, and consulting firm. Advisory Board is the leading provider of comprehensive performance improvement services to the health care sector, serving a membership of more than 3,100 organizations—including many preeminent hospitals and health systems. Leaders throughout the industry rely on insights from Advisory Board health care experts to tackle their most pressing concerns. Our expertise includes: health care delivery system transformation; improvements in clinical operations and health care quality; health care financing; health care workforce and staffing strategies; and developing and maximizing the effectiveness of health information technology and data analytic solutions.

Advisory Board's technology solutions support our members in analyzing administrative, financial, clinical and claims data to improve quality and efficiency at the individual provider, system, and population level. Currently, our technologies analyze data covering half of U.S. inpatient admissions. Our Crimson platform provides particular support for organizations moving toward accountable care and includes cost and quality profiles for over 500,000 physicians. The Crimson family of applications includes tools that help providers assess physician quality; identify gaps in patient care; stratify patients according to clinical risk; predict risk of readmissions while patients are hospitalized; engage care team members in care management; analyze and optimize physician referrals; and improve physician practice management.

The Crimson tools have demonstrated impressive results in improving quality and reducing costs. For example, Memorial Hermann, a 9-hospital health system in Houston, Texas, used Crimson to build their population health management capabilities. By enabling clinicians to prioritize patients and to deliver proactive evidence-based care, Memorial Hermann realized $23 million in inpatient savings captured through cost and quality improvements and a 29% length of stay reduction for their clinically integrated patient population. Similarly, Covenant Health Partners in Lubbock, Texas, used Crimson analytics to identify high-risk patients, enroll them in a care coordination program, and provide patient navigator support. The results include a 24% improvement in physician compliance with evidenced-based medicine and $2.1 million in cost savings for the 9,000 patients for which Covenant bore financial risk. MissionPoint Health Partners in Nashville, Tennessee, adopted Crimson to support care management activities. Since implementing Crimson, MissionPoint has seen a 37% reduction in 30-day readmissions, a 14% reduction in ED visit rates, and a quadrupling in the number of patients care managers can manage.

Advisory Board has applied its expertise and health information technology in support of numerous health care transformation projects. The state of Rhode Island selected Advisory Board to lead work with stakeholders across the state to develop a State Healthcare Innovation Plan as part of a Model Design Award from CMMI. In New York, Advisory Board has been providing strategic and operational support for the Adirondack Region Medical Home Pilot—one of the largest medical home projects in the country—and has helped pilot participants improve quality and reduce costs for patients. Oregon's YamHill Coordinated Care Organization (CCO) is partnering with Advisory Board's Crimson teams to classify their population by disease burden, understand the risk associated with each population group, and identify highest risk patients for care management efforts. In Colorado, the Colorado Beacon Consortium—a collaboration between multiple health care stakeholders in Grand Junction—has implemented Advisory Board's Crimson application to help primary care physicians and drive patient engagement.

Essential Principles of IT-Enabled Population Health Management

Our experience working with stakeholders to develop and implement accountable care models suggests several key elements for succeeding under accountable care. Providers depend on a robust health IT infrastructure to enable them to deliver better care to patients in the lowest-cost setting in a timely manner. Patients benefit from this care redesign by receiving care that is more coordinated and convenient and that more often focuses on prevention of disease or acute episodes. To achieve these beneficiary-centric goals, successful population health managers need the necessary data and health IT tools to perform three functions: a) stratify patients according to risk; b) coordinate and manage patient care; and c) engage patients.

Further, these needs will evolve over time. A key aim of federal policy should be to enable providers to achieve rapid innovation utilizing a large range of potential IT or analytic providers of critical insights. We are still very early in the evolution to population health and need to ensure that innovation is not tied up in the existing set of vendors supplying the industry today.

<u>Stratify Patients According to Risk</u>

In working with health care providers, we find that the most successful providers categorize the patients they are managing based on the patients' level of clinical risk. Thinking about patients as multiple cohorts (high-risk, rising-risk, and low-risk cohorts) rather than a single population allows providers to focus on different goals, resources, and care models for each cohort and drive greater gains in care quality. Crimson offers population risk management tools, for example, that can analyze claims data to stratify patients by actuarial risk (*e.g.* high-risk, rising-risk, and low-risk patients). The effectiveness of risk stratification grows as providers gain access to data that is closer to real-time as opposed to retrospective data they historically have depended on.

<u>Coordinate and Manage Patient Care</u>

Successful population health management necessitates migrating away from siloed care management activities and toward cross-enterprise, cross-continuum platforms. To that end, population health managers need tools that enable them to track patients' health and utilization

across multiple sites of care, both within and beyond their network of affiliates, likely with multiple EMR platforms. In addition, successful care management must extend to non-traditional sites of care, for example, social service agencies, "Meals on Wheels" programs, and patients' homes. With these tools, providers can ensure patient adherence to care plans; help patients avoid acute episodes; and collaborate with other providers on interventions.

Crimson offers a care management platform, for example, that enables care team members to develop and execute customized care programs to improve patient outcomes and reduce health care costs. The technology integrates data from multiple sources to identify individual patient needs and risks. The tool structures workflow with tailored, best practice care plans targeted to ensure each patient receives appropriate interventions from the optimal resources. The tool addresses a major barrier in population health management by providing a centralized vehicle for communication and collaboration across a diverse and decentralized care team.

Engage Patients

As providers in accountable care models seek to shift health care delivery to lower acuity settings, they will need to establish mechanisms for interacting with patients in the outpatient setting and in patients' homes to ensure successful outcomes and management of utilization risk. Health IT and data analytic tools can enhance and bypass the traditional patient engagement strategies of postcard and email campaigns. IT-enabled patient engagement includes services and platforms that combine real-time multi-modal bi-directional communication between providers and consumers; tools to support patient self-management and engagement; and incentives for patients to adhere to care plans.

In addition to supporting care coordination across a patient's care team, Crimson also contains patient engagement capabilities. The application allows patients and caregivers to view the care plan to support self-management and care plan compliance.

The Real Challenges on the Ground

The pioneering provider organizations we have been fortunate to work with in deploying technology to enable population management have been able to overcome the challenges of the current IT environment through a combination of smart and aggressive investment, determination and focus. But as we contemplate the widespread adoption of population management models and the performance expectations of managing cost and quality for an older and sicker population, we worry for the ability to scale innovation quickly enough to deliver the kind of health care system we all desire. Providers and solution vendors alike encounter too many challenges to be wholly optimistic about achieving our goals.

Each of the elements for effectively delivering care under a population health model requires access to timely and reliable information. However, providers often find access to EMR data and comprehensive claims data—two critical data sources—to be prohibitive for technical, financial, and contractual reasons. The access issues are compounded by the need for health systems and ACOs to create networks of physicians and providers (e.g., post-acute care providers) that extend beyond their owned network. Limited access to data hampers innovation,

for providers as well as third-party vendors, ultimately constraining the positive impact of accountable care models on patients.

EMR systems hold clinical data that providers need to manage care for patient populations, but most EMR systems do not offer effective tools for care management. Thus, in order to achieve population health goals, providers need to extract data from EMRs to integrate it with data from other systems. Many ACOs face the challenge of extracting and integrating data from multiple EMRs. Most major health systems today have multiple EMRs across their owned network of hospitals and physicians, and our research indicates that most providers expect to continue working with multiple EMRs for the foreseeable future. Standards are not likely to solve this problem in the near future, and the primary emerging strategy today is to aggregate information providers need to manage populations and risk by creating layers of information and data that sit on top of the EMR.

Comprehensive claims information is also necessary for a population so the health system can account for care provided outside of their four walls. Payer data is also not always available to providers without developing specific contract provisions with payers in some way.

In our experience, providers face three primary challenges with respect to acquiring and utilizing data in EMRs to manage at-risk populations:

1. Difficulty acquiring and using data from EMRs: Some EMR vendors impose contractual and other constraints on health care providers' ability to use data that is contained within the EMR. EMR vendors may require that the hospital or physician's staff that seek to extract requisite data, such as medication lists, are certified by that vendor. Obtaining certification and hiring and using internal staff can be costly and time consuming for the provider. And third parties engaged by the provider to assist with extracting and using that data to benefit the health care provider and its patients are routinely requested to sign restrictive access and use agreements. The restrictions in those access agreements make it more difficult for the hospital and other organizations to innovate and could limit a hospital's ability to use data in a timely manner to improve its population health and care management initiatives, as well as revenue cycle processes.

2. Difficulty acquiring data from systems that are not commonly messaged for typical inpatient activities: In a given health system, only a portion of patient data is available via the organization's integration engine in real time. The rest of the data, depending on the vendor, is often only available in nightly batches or not at all. For example, physician and nursing progress notes, which often contain very useful data to determine patient risks for adverse outcomes, such as risk of readmission, are difficult to acquire without the proper interfaces (which may require a significant additional investment from the health system). This challenge is more acute in the ambulatory setting where relevant content, like physicians' schedules and availability and patient problem lists, is rarely available to third-party vendors in a standard way (schedule information is crucial in determining patient access bottlenecks, an important metric when managing a population).

3. Difficulty pushing data and derived insights into the EMR workflow: After acquiring the requisite data for our applications to determine outlier physicians or high-risk patients (for example), we sometimes encounter additional challenges in our ability to inform the user of our insights within the existing workflow system. Necessary additional data or work flow "real estate" are not available to operationalize insights. And while a few organizations have been able to overcome these barriers, even the most well-resourced and sophisticated organizations face nearly insurmountable barriers and the vast majority of organizations have no secure or predictable method to achieve this goal.

In addition to the data access and technology barriers I described above, we help providers address a few other key challenges as they pursue accountable care.

Physician Concerns

Physicians express many concerns about adopting and utilizing health IT. Incorporating health IT into workflow can require more time in physicians' routines, and the more health IT that ACOs try to implement, the more that physicians feel health IT 'fatigue'. Similarly, some physicians worry that health IT may disrupt their relationships with patients or interfere with clinical judgment. In addition, physicians in independent practice or small groups lack the financial capital to invest in the applications necessary to succeed in accountable care. Ultimately the biggest challenge to physician adoption of health IT is the lack of effective financial incentives—even physicians who are early adopters of accountable care models still receive significant portions of their revenue through traditional fee-for-service payments. Until population health management incentives overwhelm fee-for-service incentives, physician skepticism could pose a significant barrier to health IT investment and utilization.

Patient Concerns

Where patients don't have incentive to share their data (or where data sharing is voluntary), they often resist sharing their data because of skepticism about the use and privacy of their data. Barriers to patient sharing of data—including the lack of incentives and unresolved patient privacy concerns—restrict the flow of data necessary for successful population health management.

Mitigating Barriers to Effective Health IT Use in Accountable Care

As we talk to our provider customers, it has become clear that there is a need to solve barriers associated with data access problems to enable successful accountable care models. Options for addressing these challenges that are often raised include:

1. Stage 3 of Meaningful Use could require EMR vendors to provide a standard Application Programming Interface (API) or set of APIs that enables other health IT programs to extract data from and input data into the EMR. To be effective, the API would be published, public, and open to any third-party vendor for use. ONC could use EMR certification standards to enforce the requirements. Federal oversight can help ensure that the use of commonly required APIs expands over time. Vendors who do not continue

to meet the API requirements would not have a certified health product and therefore would not be included on the Certified Health Product List. Alternatively, health systems may want access to additional information on vendor capabilities regarding API availability to better inform their choices.

2. ONC could also further specify data standards for data transport between systems. Current standards make data transfer possible, but they do not make it financially viable. ONC could consider advancing policies that create a business case for reducing the cost of data integration. Pushing down the financial barriers to data integration could spur rapid and broad innovation.

3. HHS could examine policies that drive greater data sharing between providers and payers to facilitate better population health management. At a minimum, providers should be able to access full claims information as part of any risk-sharing arrangement. Further, restrictive data use agreements and other limitations created by health IT providers, particularly those involved in the day-to-day flow of information, could be examined to determine the impact on the ability of health providers to adopt innovative solutions that will be created to address population health needs.

Longer term, several additional developments could facilitate continued innovation in, adoption of, and success with health IT solutions for accountable care-focused providers. Options that are often discussed include:

1. Implementation of better patient matching options, including either a national patient ID or some other solution to help unify patient-level data across multiple systems, such as patient-mediated data exchange.

2. Increasing standardization around clinical data and nomenclatures to reduce ambiguity of data being transferred.

3. Creating incentives for patients to share data to help overcome some patients' hesitance to share data with their providers.

Conclusion

Ultimately, continued payment transformation itself (in both the public and private sector) will be the most impactful driver of health IT-enabled accountable care. Multi-payer accountable care models could have a particularly meaningful impact as current ACOs tend to have a significant portion of business in traditional fee-for-service models, diluting the impact of accountable care incentives.

As providers adopt new delivery and payment models in the transition to accountable care, the potential improvements in patient care and financial benefits to the health system will foster a new paradigm of health IT utilization. Providers will seek health IT solutions for identifying attributed populations, tracking patients' health care utilization, identifying gaps in care, collaborating with other providers, and helping at-risk patients avoid disease or acute episodes.

However, it is essential that the health IT environment is conducive to innovation, investment, and predictability for IT-enabled population health to achieve its full potential.

Thank you again for the opportunity to provide this statement. We applaud the Health IT Policy Committee's commitment and leadership on this issue and we look forward to working closely with you in the future.