Written Testimony for HITPC Accountable Care Workgroup Hearing

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I appreciate the opportunity to testify today. It is undoubtedly a unique moment the evolution of the US health care. A substantial portion of health care providers recognize that the future delivery system will look significantly different than it does today. However, the transition from "turnstile" medicine (getting paid for the number of people who walk through your doors) to value-based care and accountability for population health is not easy, linear or predetermined. The roadmaps, incentives and infrastructure that exist have the ability to dramatically affect the trajectory and the ultimate success of new payment and delivery system models.

Indeed, these roadmaps, incentives and infrastructure already have – in both positive and negative ways. Stage 1 of meaningful use (MU) provided a great foundation for delivery systems in making the transition to value-based care. Those providers that have not only made the resource investments but have also used MU as an opportunity to alter care delivery processes are much better prepared for accountable care models – both than they were previously and in comparison to other providers that "met the mail" in implementing MU. In places where providers have contrived workarounds to "check the boxes" on MU, they find themselves struggling from a data integration and infrastructure perspective. Specifically, they cannot find and/or integrate the data they need to: robustly measure performance; identify individual needs of patients to tailor care management; right-size their population health resource investments; or reward clinicians appropriately for the level of value they provide to their patients.

What is also clear about MU as it relates to population health is that Stage 2 cannot get here fast enough. Although Stage 1 is a good platform on which to build, many providers cannot get the data they need, when they need it and how they need it in a Stage 1 world. Most notably, the Stage 1 EHR provides information basically about a particular patient in one particular setting rather than bringing information in from the person and the multiple settings that he or she may be getting care and managing health. Providers' robust access to transition-of-care summaries and patients' ability to view, download and transmit their personal health information are prerequisites for effective population health management.

Undoubtedly, Stage 3 functionalities will have further benefits for those delivery systems building infrastructure for accountable care, especially if Stage 3 MU requirements facilitate the efficient incorporation of patient-generated health data, including the ability to measure patient-reported outcomes. As MU requirements increasingly help evolve the EHR from its one-time function as a digital medical record to its MU orientation as a longitudinal population health management tool, other functionalities will be critically important to providing the necessary infrastructure. Many ACOs have focused their population health priorities extensively on how to manage care for people with complex needs. As it turns out, many of the issues that drive high-cost and inefficient care relate less to clinical needs than social determinants of health, yet current data focus almost exclusively on the former. HIT systems must incorporate social issues or they will not serve the needs of ACOs in managing these populations. In addition, in the future, meaningful use of EHRs must evolve the EHR so that it can be used by the full array of the care management team as opposed to a tool that exists only for personnel situated within the four walls of the clinic or hospital.

In discussing the challenges of making value-based care models work, I was recently asked if those challenges are due to complexity versus "simple but complicated." In other words, is that we know what to do but it's just complicated to get it done? I think it is some of both. There are definitely many different tactics that we know will help delivery systems maintain accountability for population health, but there are two sets of challenges. First (on the "simple but complicated" side), there are so many different components to making population accountability successful; nowhere is this more true than in the integration of multiple data sources. The combination of different standards, incompatible systems, unstandardized data flows and incomplete documentation creates countless opportunities for potential errors to occur. Even once these sources are functionally integrated, generating manageable reporting tools also is a remarkably complicated task—how to balance the need for sufficient granularity that the information is actionable with the demand for clarity and succinctness that today's leaders demand.

However, there also are complexities that arise in significant part from issues of external validity. That is, we know what may work in particular circumstances with respect to the organization of data and care management activities, but that doesn't mean that we can extrapolate that effectively to the wide array of care and data settings for which care management tactics need to function. For example, there are some excellent emerging best practices regarding how to restructure primary care delivery. If we were starting from scratch and could geographically organize patient and provider populations in efficient ways, we could "simply" apply those approaches. In many cases, economies of scale do not exist to allow for this wholesale redesign, and we also need to be mindful of completely disrupting existing patient-clinician relationships.

An additional piece of this puzzle that probably straddles the complex/simple-but-complicated fence is the sheer messiness of the transition period. On its face, this may first appear to be a simple-but-complicated challenge – what is the right timing for launching different aspects of providers' value-based care strategies? However, it's really more complex because of the fundamental contradiction in business models for providers operating in fee-for-service versus accountable payment models. Living with a foot in each of these two payment worlds is enormously complex, and the fact for most providers is that – even for progressive delivery systems – only a small fraction of their current financial sustainability derives from value-based payment models.

A lack of robust health information exchange creates data silos that pose enormous obstacles to delivery systems trying to manage population health. Data silos prevent effective communication about patient needs, compromise providers' ability to measure and address quality-of-care issues, and prevent proactive identification of patient needs. These silos of data further reinforce other existing silos in health care, the most obvious being the silos of providers. In addition, these data and provider silos also breed silos in ACO "solutions" that exist in the marketplace. That is, HIT vendors, consultants and other ACO solutions providers frequently offer providers a series of disparate tools and services. Each of these offerings may well be useful, helpful, meaningful and even innovative in addressing one component of a delivery system's transition to accountable care, but the piecemeal application of such solutions may do little to drive greater overall capacity for managing population health. In some ways, these creative solutions to complex problems still leave the delivery system with a series of extremely complicated challenges in figuring out how to assemble these distinct puzzle pieces.