HIT Policy Committee
Accountable Care Workgroup
Hearing: Accountable Care and HIT
Summary FINAL
December 5, 2013

KEY TOPICS

Call to Order and Roll Call

Michelle Consolazio, ONC, opened the hearing with the Federal Advisory Committee (FACA) announcement. She referred to the opportunity for public comment and said that a transcript of the hearing will be posted on the ONC website. She reminded members and panelists to identify themselves for the transcript before speaking. She reminded the invited panelists that their testimonies were limited to five minutes. Members, staff, and panelists introduced themselves.

Opening Remarks, Meeting Objectives and Expected Outcomes

Accountable Care Workgroup Co-chair Charles Kennedy remarked that although health IT has advanced over the past years, dissatisfaction with the infrastructure continues. He said that the objectives of the hearing were to:

- Understand how stakeholders use health IT to satisfy cost and quality business objectives under different accountable care arrangements, learn about innovative solutions which should be replicated and spread, and understand the key challenges to adoption and implementation.
- Elicit ideas and perspectives about how policies and programs within the Department of Health and Human Services can further the evolution of an HIT infrastructure to drive success for providers under accountable care arrangements.
- Receive specific input on whether and how modular certification of health information technology (broadly defined to include EHRs as well as other applications that may interact with the EHR) focused on population health management functions and interoperability standards would help accelerate success among entities engaged in accountable care arrangements.
- Receive specific input on how the Medicare Shared Savings Program can encourage development of health IT infrastructure and capabilities.

Overview of Accountable Care Landscape

Clif Gaus, CEO, National Association of Accountable Care Organizations (NAACO), reported that his organization has 77 member Medicare ACOs and 53 business partners. Membership will be expanded to private payer ACOs in 2014. The market is becoming more concentrated. There are 23 Pioneers, 220 MSSPs and 235 private payer contracts. Fifty-five organizations have both, resulting in a total of 423 organizations. He estimated that 150 new ACOs will form in 2014. He acknowledged that it is difficult to obtain good quality data on ACOs' performance. The first year of the Pioneers showed universal quality improvement, but mixed financial results. The early targets were reducing readmissions, managing less SNF use, better coordination with specialists, and managing chronic care to avoid hospitals. He reported on a survey of ACOs conducted by NAACO. (No information on sampling, response rate or representativeness was given.) The findings were based on 35 responding organizations, reportedly a "mix of types, sizes and dates." The "average" beneficiary count was 20,413. The predominant governance model was one legal medical group entity with or without a hospital. Some were very complicated with over 100 different legal entities defining the governance structure. Estimated financial expectations were very mixed. First year savings and losses ranged from a $4 million gain to a $10 million loss. Over half of the respondents said that they did not know. The start-up costs are such that investors and managers are taking up a huge risk. Respondents' estimated startup costs averaged $2,243,216. One third of them have acquired debt to a bank, line of credit, owners' notes or CMS Advanced Payment recoupment. When asked to name their most vexing problem, 50 percent responded IT. Gaus explained that participants' organizations typically have different EHRs and usually cannot communicate clinical data with the ACO network. Since much care occurs outside of the ACO, the communication problem is even more severe. ACOs are handicapped from coordinating care by the lack of appropriate IT. Although adoption is high, the lack of interoperability is also high. CMS could help by requiring that ACOs receive and send notifications of admissions of line beneficiaries to acute care, EDs, and SNIFs.

Q&A

ACOs would benefit from the definition of a common data set that can be extracted from clinical records. In a few communities HIEs are helping. Vendors need incentives to build interoperability. They reportedly do not have a vested interest in interoperability. Centers for Medicare and Medicaid Services (CMS) and ONC should investigate the barriers and address them.

In response to a question from Tang, Gaus acknowledged that providers resist sharing data. They compete. This behavior can be changed via incentives or regulations. When the political world and the public understand that there is no interoperability, there will be an outcry. After the investment of considerable resources, the public expects more. The ACOs are not the solution to interoperability although they will be active advocates. ACOs are mostly small organizations. They are learning, but they are under-capitalized and at financial risk.

Leslie Kelly Hall inquired about sufficient data to manage patients and risk. Gaus replied that there are ample data to reduce costs via low hanging fruit. Claims data can identify practice patterns that need to be changed. CMS must provide good quality claims data. But ACOs need to figure out how to use these data more effectively. Beyond that, patient engagement, long term impacts, and social care cannot be served by claims data. Quality measures are a work in process; not all payers are on the same page.

David Lansky asked about success stories and Gaus mentioned that some ACOs have created the IT infrastructure. There will be success stories later. Much is unknown about how an ACO changes behaviors, but the changes do not always result in cost savings. One issue is that the time period of claims data is not in sync with changes in the population; the numerators and denominators do not jive.

The business model is such that losses due to leakage must be replaced. Hospital-based ACOs have a lot to risk. If better care coordination results in empty beds, then they need to replace that revenue. Frequently, they try to fill beds by increasing market share, which increases competition in the community and may drive out smaller entities.

Behavior health (BH) is increasingly important. Not having access to substance abuse claims is a large handicap. It would help if HHS could figure out a solution. Some mental health claims data are available, but there is sensitivity around privacy and security.

Panel 1: Physician-Led Accountable Care Arrangements

Moderator: Grace Terrell

Larry Garber, Reliant Medical Group, testified that Reliant Medical Group and Atrius Health have achieved the triple aim of improved health care, improved health, and reduced health care costs through the implementation of an EHR, patient engagement and home monitoring tools, health information exchanges, robust CDS tools, and comprehensive analytics and reporting tools. The United States can achieve triple aim through standardization of a National Provider Directory Network, Community Master Patient Indexes, Relationship List Services, Significant Event Notification Documents (SENDs), patient authorization requirements for release of information, home monitoring device integration, and an orderable test compendium. Accurate data for quality reporting can only be obtained if the data can be re-used for multiple purposes such as patient care, communication during transitions of care, billing, and documenting meaningful use of EHRs. Unified metrics, document formats, and vocabularies will be required to make this possible. He reported on results, saying that Atrius's ACO significantly exceeds the Pioneer ACOs' mean on most quality and outcomes measures, and is among the best in the nation in many measures. Costs are lower than the four other Massachusetts Pioneer ACOs.

Michael Weiss, Monarch IPA, did not submit written testimony. He reported that his organization is in its third year as a Pioneer. Although his physician-led ACO is affiliated with hospitals, those hospitals are forming their own ACOs and due to the competition will not share data about patients. Only half of the physicians have an EMR, but not the same EMR. About 43 percent of the ACO population is included in an EMR. A proprietary system is used by office staff (not usually physicians) to identify gaps in care. He emphasized the importance of office staff is achieving efficiencies and implementing processes. These are one to two doctor offices. They do not know CPT codes or ICD-10. He pointed out that provider and patient identification is essential, because much of the patients' care is from physicians who are not part of the ACO. The vast majority of expenditures are to specialists. Patient notifications are essential for ACOs. He asked that consideration be given to the support of independent physicians.

Stephen W. Nuckolls, Coastal Carolina Health Care (CCHC), described some of the IT issues encountered by his organization. One of the main challenges is that the systems are still being developed. A lot of time is spent on education of management and technology partners. Although many solution providers are available, better tools are needed to compare and identify variation in costs among populations to help pinpoint areas where waste can be eliminated. He explained that CCHC uses its EHR as the central repository and makes data available to patients via a Web-based portal and to other community providers by secure view only access. While the data had been available for some time, there were not fully appreciated or used until CCHC hired a nurse navigator and placed her in the ED to print the data for the providers and assist with the care transitions. The MSSP incentives create the business case needed to support the clinical need. MSSP ACO's face challenges with the claims data made available. Complete data are needed for a number of purposes including: accurate profiling of provider practice patterns, implementation of reliable physician incentive programs, and ability to determine detail changes in utilization between periods. A complete data set will enhance accountability and increase engagement and performance. Patient confidentiality can be protected by removing identifiable data and prohibiting the linking of these specific records to other clinical data. Since the EHR serves as the central repository for data, considerable effort is exerted in re-entering data (laboratory results, problems, medications, history, etc.) received from external groups, and outside groups spend time reentering data sent by CCHC. This process could be enhanced if EHRs could send and accept these discrete data. Any policies designed to enhance this transfer (i.e. designating standard fields and requiring this functionality.) would be helpful in supporting ACOs' continuity of care, population health management, and clinical decision support activities. The group's development of advanced reporting, population health management, and care coordination would not have been possible without the advance payments supplied by CMMI. ACOs need to develop institutional knowledge on clinical quality reporting and improvement initiatives. Separate payments are required to support and achieve these goals. If 12 percent more is spend for patients enrolled in Medicare Advantage plans than for traditional fee-for-service plans, then it should be possible to spend an additional 1-2 percent investing in the necessary infrastructure to operate an ACO. CMMI could support development of more advanced HIT functionality and ACO development by expanding the advance payment model to non-rural physician organizations with significant primary care operations that otherwise would not have the necessary funding (i.e. non-hospital based entities).

Troy Tyner, who is in private practice, described the time wasted and potential disasters when patient information cannot easily be accessed across providers and systems. Each EMR and HIE provides a different snap shot of the patient's care. Patients have a different portal to get information about themselves from each physician they see. They have the PCP portal, their urologist portal, orthopedic portal, etc. Each has a different user name and password. All tell a different story with all the silos of misinformation. What is needed for a successful ACO model is a single understanding of the patient not multiple understandings. As circumstances are now, the meaningful use criteria drive things to a document-based model. Connecting the data silos does not drive quality but raises costs and hampers data mining and efficiency. In striving to improve care, communities have developed and launched health information exchanges utilizing the existing criteria, but they have failed to live up to the promise. They do not have all the data about patient care and if they did, they do not provide actionable data to drive quality for the individual let alone the community. Existing vendors do meet the meaningful use criteria as written but they are not motivated in working together to improve things. They are ignoring the issues. They are very slow to respond and their architectural requirements hamper and constrain their products. He said that in his heart he thinks they all realize they have a Potemkin village. The answer is a patient-centric model.

Craig Behm, MedChi Network Services (MNS), described efforts to form ACOs in rural areas of Maryland. The largest IT challenge is data sharing. Creating two-way interfaces between certified EHRs and the MNS data warehouse is costly and time-consuming. Many vendors offer solutions for data sharing, but they require all users to be on the same platform or expensive fees (or both). There are over ten different EHR systems in use across the ACOs. It is impractical to require small, primary care practices to absorb the high cost of switching to one uniform technology. Stage 2 offers some hope through DIRECT exchange, although physicians are required to purchase and implement system upgrades which may not happen for some time. In addition to the technical challenges, all ACOs are facing significant workflow issues. Community physicians must have access to extensive patient data at the point of care to be successful in an ACO model, and clinical data must flow back to the ACO. EHR interface restrictions mean that some other method must be utilized to relay data at the point of care. MNS created a simple Web portal to allow office staff to enter data prior to a patient's visit. Because the Web portal automatically displays known data from the data warehouse, any missing values are also an indication of overdue patient services. Ideally, this would be managed directly through EHR systems, but it is not practical at this point. Behm explained that community practices are overwhelmed by the myriad of changes in health care reimbursement and policy. Health IT, especially in independent practices, has been lagging behind most other industries. The physicians MNS is working with through the ACO program are the people who can support institutional change; they are in rural communities with defined populations; they are low-cost providers whose largest expense is running a small business; and they are eager for support as more and more changes affect their industry. While each of the groups is technically a competitor, they embraced collaboration through the ACO model because they knew it would enhance their patients' lives. The physicians would not be working together in an ACO if it were not for Advanced Payment and other similar initiatives. The physicians have never worked together before; some have never been on a board. They are neighbors and competitors, and some do not like each other. MNS supports efforts to standardize data-sharing and to increase data liquidity. Significant resources are devoted to gathering data from multiple sources and making the data accessible at the point of care. EHR systems do not have the population health capabilities to perform analytics required at the ACO level. It is impractical to expect a physician to log into multiple portals from multiple databases (hospitals, commercial insurers, and others) prior to interacting with each patient. Physicians should have access to their patients’ data in a universal format, and in a straightforward manner, so that it may be tailored for practice workflows that support quality and patient satisfaction.

Q&A

Terrell referred to four questions in addition to the 11 questions asked originally for the written submissions. She proceeded to ask a question on high-value clinical strategies. According to a panelist, one successful strategy is to track ED visits and admissions for daily review by the medical director who subsequently communicates with physicians. A monthly report is prepared. This project increased doctors’ engagement. Another panelist described daily feeds to identify hospital admissions so that hospitals and PCPs could immediately engage on care transitions. Garber talked about CDS and accuracy from alerts and registries so that no false positives are generated. CDS is from multiple sources.

Responding to a question about actionable quality measures, Garber talked about actionable deficiencies, creating a score of how actionable a deficiency may be, and, first, addressing the most actionable deficiency. Behm talked about transitions of care, notifications of discharge, and calling the patient to schedule a follow-up visit. These steps were taken to prevent readmissions.

What about the single understanding of a patient and the data foundation? Garber said that he works in a highly integrated system of ambulatory physicians. They get all hospital data into their EHRs. They used IT to create an integrated environment. Another panelist talked about having five different registries with patient information. Another panelist described semantic overlay. Someone spoke about using single understanding to motivate everyone. Misinformation is a problem. One understanding is the key, which goes beyond interoperability.

How much of the work could be done by those who aren’t medical doctors? Hiring more workers would impact the budget. It is better to use IT to have one understanding. Another panelist acknowledged that physicians are not trained in running offices. His organization redesigned primary care offices. Studies indicate that 60-70 percent of what a physician does on a daily basis could be done by someone else. Garber said the registries are run by workers who also act as health coaches. His organization has used IT and non-physicians to increase efficiency. The use of EHRs allows substitutability. Behm said that doctors are doing a lot of data entry because of the rapid rollout.

What motivates the doctors to take action on actionable items? A panelist described using the updated dashboard, which can be viewed at the office visit. Nursing staff takes care of many of these items in preparing the patient for the physician. Another panelist said that an efficient paper process can be translated to an electronic format. Actionable items can be discussed with the patient when she calls to schedule appointments, during the visit, or staff can call her.

Karen Bell asked about shared care plans and engagement of providers outside of the ACO. Nuckolls described the use of care managers to assist with self-care of frequent flyers; care managers work with the doctors. Most of the shared care planning is not IT-focused. Garber described 200 patients being on home BP monitors with the data coming into the EHRs for review.

What about examples of inconsistencies in data driving to harm? One panelist talked about using beta blockers and other proven protocols inappropriately. Garber described using claims data and face-to-face visits to clean up the data. Someone reported on the importance of accurate data in engaging the physicians.

Regarding integrated claims, what about the problem of multiple screens? And how does one design systems to deal with physician culture? Garber said that his EHR is structured so that data are filed in the same place regardless of the source and the data are searchable. Another panelist said his system is much less integrated. He uses a data warehouse and Web services interface. The point is to get data to the doctor in whatever way possible.

Terrell asked about policy to improve ACOs. Tyner noted that IT vendors are constantly changing staff. Getting vendors to work together is a great need. Perhaps there could be a requirement for regions to work together to share data. Although competition may be wonderful when it reduces costs and increases quality, competition among vendors has not helped providers. Garber declared that ICD-10 has no value; CMS should harmonize in terms of what is efficient and truly necessary.

Mickey Tripathi asked Weiss about barriers insofar as he used EPIC, which seems to work for Garber's operation. Weiss said the data are static. To import data is impossible. Pulling up data results in multiple screen shots. He does not use EPIC for analysis because the data are not inaccurate. He uses it only for patient care, but even so the result is pop-up fatigue. Vendors will not disclose solutions devised for other clients so every solution must start at zero. The Ohio HIE has not helped to resolve problems. Someone referred to another HIE in Ohio which is better. Garber said that vendors do not recognize the difference between data that are opinions and data that are facts. Facts can be loaded into the EHRs without human interaction.

Weiss reported on the practical impact of competition in Orange County. The aggressive recruitment of physicians into ACOs makes it difficult to work together to integrate systems and workflow. A panelist suggested that a solution to the downside of competition may be to require electronic reconciliation of referrals. The extent to which patients sent for referrals have their records sent with them may be a measure of working together. Tyne said that although many other countries use linked platforms, they still have similar issues. He suggested learning from the experience in the United Kingdom.

Terrell attempted to return to policy recommendations, asking what constrains could apply to ACOs. Behm suggested investigating how vendor products actually work at the point of care. Someone referred to a bill that would pressure vendors for better transfer and reconciliation of information. Garber brought up transaction fees charged by vendors, saying that fees restrict exchange. Vendors impose fees for both sending and receiving. So providers will send just enough to meet meaning use requirements. He asked about a regulatory solution.

Tang referred to small practices, low prevalence of EHRs, organizing EPs who do not like each other and asked the panelists why are doing ACOs. He explained that he was looking for a policy lever. Weiss said that EPs in his environment have been working with managed care and care coordination for many years. They have the data to show that it works so working together is the culture. But that culture is endangered by current hurdles. Behm said that community doctors knew the challenges and knew they must change; they agreed to try an ACO because they had nothing to lose. Someone referred to metrics demonstrating value to the patient first, and then to the physician, which in turns helps the organization.

Regarding quality metrics, someone said that the universe is immense. If the workgroup came up with a list of standardized metrics, would that be helpful? Panelists agreed that standardized metrics would be helpful. However, sometimes metrics are introduced too quickly and drive to metrics rather than care for patients. Metrics must use evidence based medicine, meaning evidence from repeated trials and not findings in one article. One set of metrics would help. Metrics reported by a non-vertical organization do not accurately reflect the work being done and they do not motivate physicians. They see it as data chasing.

Claudia Williams, ONC, asked Behm about alerts for admissions, which is relevant for specialists as well as PCPs. What policy interventions could motivate components outside the ACO? He responded that in Maryland, one sweet spot is the three-day transfer rule. Garber spoke about incentives for home health and the hospital at home program. With his Impact project, he found that nursing home administrators wanted to participate because it helped them to demonstrate quality. Another panelist said that DRGs constitute incentives to reduce hospital days.

Consolazio advised the members that the discussion had exceeded its allocated time. She asked them to be brief.

What can HHS do to scale notifications? One panelist replied that HL7 standards for vendors was the key. But another panelist explained that the HL7 standards vary. When asked whether it would be helpful to know what ACO vendors can actually do with consumption of cost data, panelists were not enthusiastic. One panelist opined that statewide standards would be a good idea.

A member mentioned NIH NCI PROMIS. Are ACOs ready for patient reported outcomes and would core measures be useful? Garber explained that there is a low limit on how much of this patients want. They must perceive some value in order to participate. Someone declared that CAHPS and some other PROs are ridiculous

Do some measures present too low a floor? What are suggestions for better, innovative measures? Tyner suggested hypertension with BP monitors seamlessly loading the data, as well as lipid. Both are important and easy to collect. In California, immunization and bundling of measures around disease process, such as diabetes, are used.

What about privacy and security barriers to data sharing? A panelist reported that use of Epic's Care Everywhere is resulting in patients imposing barriers. Another panelist reported that the vast majority of patients want to share data, but 5 percent want to control everything. He urged designing for the 95 percent and accommodating the 5 percent.

EMRs and ACOs tend to be silos: How can the private sector be incentivized to exchange information? One panelist said that there is a technology gap. Other industries can use IT to anticipate what data are needed. HIT vendors must get up to speed. Garber recommended making standards so that data can be used for multiple, different purposes. CMS could reimburse vendors' transactions fees. Vendors could report their transactions and bill CMS. Someone else said to convince vendors of the value of changing systems. Then customers will stay with the best systems. Another panelist said that the practice management system could be disconnected from EHRs to allow physicians to go with the best EHR product.

Panel 2: Implementers – Hospitals and Providers
Moderator: Charles Kennedy

Michael Sills, Baylor Quality Alliance, referred to his written testimony. He reported that although his organization uses many tools, each seems to have barriers to integration with the other tools. There is no incentive for his vendors to cooperate, even though he is one of Epic's and Allscripts' largest customers. The local HIE does not work. Consequently, he has focused on aggregating information from the multiple EMRs to create an integrated data source that can be quickly ported to any clinical or financial analytic solution employed. More than 50 different electronic medical records are used across his system. Many of them are unable to automatically produce CCDs. The cost of connecting all of these EMR is untenable. Not all of the constituencies across these systems are comfortable with aggregating clinical and financial data. Without as close to real-time, reasonably complete information, it will be difficult to identify high-risk patients and intervene in their courses of treatment. There is little market pressure to force vendors to agree on any common data source or mechanism of storage. Until a more agnostic platform is agreed on there will be fragmentation in data sources. There does not appear to be enough leverage in the marketplace to force commonality in data aggregation. There are no standards for big data. The information from CCDs is limited and too often not automatically updated. Any policy around enforcement of standardization and requirements for production of information automatically would dramatically improve the ability to manage populations.

Charles Chodroff, WellSpan Health, said that WellSpan is migrating its business model from fee-for-service payments to accountable care relationships. It entered into an accountable care relationship with Aetna this fall and anticipates additional ACO relationships with other payers over the next five years with the expectation that most of its revenue will come from these types of payment arrangements. He observed that to date many of the requirements of the HITECH act have focused on providers. He urged a greater focus on coordination with payers and consumers. He suggested better identification of specific individuals in the managed population who are at highest risk, improved ability to proactively identify patients in populations covered by accountable care arrangements, and additional actions that will help patients and community support groups engage electronically to manage high-risk individuals in the community. The current meaningful use requirements do not segment the served population according to risk. The requirements for communication, coordination, and automated interventions are the same regardless of the severity of illness, absence or presence of social or community supports, or anticipated resources needed by the patient. But the success of most accountable care arrangements depends upon payers and providers assuring that those at most risk of unnecessary costs are quickly identified and managed. ONC could require providers and payers to adopt a standard methodology that assigns a risk score to help categorize patients. Several methodologies are publically available based on research supported by AHRQ that calculate an estimated risk of health deterioration. A standard set of data fields and set of data definitions would enable both providers and payers to immediately focus on those who need case management services. Patients and their family members would recognize that they have been identified as being at risk for a complication and might be more willing to accept care management services that otherwise might be wrongly dismissed as unnecessary or extravagant. These requirements, combined with case management tracking functionalities, could be part of voluntary certification of HIT applications designed to help ACOs manage their populations. In addition, proactive identification of those in the assigned population using a universal patient identifier would help coordinate patients. ONC could work with payers and providers to facilitate the identification of individuals in the accountable care population prior to the beginning of a risk period. He also proposed several ways to better engage patients, families, and community support groups in the coordination of patients, particularly palliative care plans and end-of-life interventions. Part of this effort would involve enhancing future meaningful use requirements such that providers have the requirement to collaborate in the management of a common, patient-developed shared care plan, managed by the patient electronically, that could then be linked to faith-based organizations, community support agencies, and other members of the public who are part of the individual’s social support system.

Frank Bragg, Eastern Maine Healthcare Systems, did not submit written testimony. He talked about the multiplicity of EHRs used in his organization. HIEs can be a solution. He suggested getting Consumer Reports to evaluate usability. EHRs should move toward limited number of platforms and increased use of external apps. Patients do not want portals; they want to use social media. Requirements must be flexible and up to date. Nursing homes could be incentivized to use EMRs that push data to EPs. ONC can demand that vendors offer integration of claims and quality data.

Anthony Slonim, Barnabus Health, did not submit written testimony. He spoke about ACOs as umbrellas. His organization does not work with Medicaid. It is important to recognize that the outpatient arena is much less coordinated than hospitals. The outpatient coordinates and sees that labs, prescriptions, and consults are carried out. In the hospital, the staff does the coordination. The payer pays every intersection point for the outpatient. For inpatients, the payer pays the doctor and the hospital for the coordination. He indicated that readmissions are not an issue in his system. Participants in the ACO use 15 different EHRs. Participation in multiple HIEs and patient engagement are ongoing concerns.

Q&A

Members were told to stay with the predetermined questions.

Pertaining to the question 1, in terms of planning to improve quality and reduce costs (often conflicting goals), one panelist reiterated that hospital revenue depends on filling beds. Incentives must be re-aligned. Smaller systems will not be able to survive population management. Many hospitals will likely be forced to close. Chodroff described the use of case managers and social workers and moving case managers from hospitals to the corporate level. Medical home and case management staff are used to reduce unnecessary admissions and readmissions. High-level images have been reduced. Inpatient revenue will decline, so costs must be reduced. Integration is the key. Braggs talked about the need for major upfront investments. Someone said that he was not so worried about loss of revenue because many will continue to over-utilize inpatient services.

Concerning leveraging community care coordination across systems and e-engagement with patients, a member asked about the home for the longitudinal patient record. Braggs said that the HIE would be the logical home, but some HIEs are reportedly in chaos. An aggregator at the community level is required. The HIE makes sense for Maine. Another panelist said that a home is needed for curating, not just sharing, data. One panelist observed that community is not defined.

What about sharing rather than just storing the information? Sills said that the Dallas community is vast. Who and what defines that community and who is responsibility for it? Guidance on integrity and maintenance is necessary. Another issue is who can access the information. What data can managers look at to evaluate their doctors? What about attribution? Ideally, one wants to have all information on a patient available at the local level. Someone spoke about the importance of a longitudinal care plan. Another panelist noted that the public health language (population, community) being used does not resonate with community doctors who are responsibility for team based care.

Referring to question 4, a member mentioned a merger of hospital, long term care, and quality improvement membership associations. He asked about tactics to control clinical leakage. In Cincinnati, 30 competing organizations agreed to upload their panels. ADT feeds were instituted. Chodroff responded that it starts with benefit design. If the patient can go anywhere, leakage is difficult to control. One organization uses IT that interferes with any referrals outside the ACO. Another intervention is making practice patterns highly visible to all via a dashboard. Immediate notification may not make that much difference. Many non-medical factors are involved in a patient's decision about seeking care, for instance, transportation and convenience. Another panelist said that it was not so much of a physician issue; it's a systemic problem of limited access to primary care by non-professional level employees. Braag talked about a monthly leakage report. Another panelist reported on discussions with representatives of contiguous ACOs So far, they have decided to just take into consideration the best interests of the family.

Tang referred to questions 4 and 8 on community infrastructure and vendor issues: What are the critical factors and what can be done in terms of policy? The problems do not lend themselves to IT solutions. Governance appears to be lacking. Slonim reported that sometimes the vision needs to be better defined. Other panelists commented. HIE funding is lacking. There is no incentive for hospitals to cooperate. Organizations often belong to several ACOs; each membership incurs a fee. Hospitals may belong to several different HIEs. Bragg suggested a national HIE. According to Williams, the experience in other countries indicates that upping the scale does not solve the problems.

The question of how to manage patients' use of community social services was posed. Chodroff acknowledged that ACOs must move away from the medical model. Slonim talked about BH providers creating a network of services, including community support services and integration with IT platforms.

A panelist observed that whoever owns the data has the power and power is not given away. The reconciliation of the data is the work to be done. When we have good use of data, we will deliver them to whoever can purchase them. Another panelist observed that since community organizations do not have the resources to provide information electronically, it is still possible to manage patients with faxes. All that is required is a standard set of information. Someone noted that vendors have not had time to respond to these many needs; they typically have a 10-year development cycle.

Ross referred to question 6. Is there a market for voluntary certification?

Panel 3: Community-based Accountable Care Arrangements
Moderator: Joe Kimura

Troy Trygstad, Community Care of North Carolina, did not submit written testimony. His organization provides wrap-around services to medical homes. Collaboratives do not take on risk directly. Their risk is indirect. Members share processes, HR policies, resources, and IT. Patients are assisted in navigating across components. One advantages of a collaborative is that is serves patients across place and tax IDs. A collaborative increases the denominators. He noted that 50 percent of patients of academic centers are discharged to medical homes outside of their catchment areas. A community collaborate can take more of a neighborhood home approach. Admission data must be accessible and timely. Having a claims repository for SCHIP, Medicare, and Medicaid is an important asset. He recommended including behavioral health and pharmacies. He requested a national, unambiguous definition pertaining to privacy of substance use treatment information.

Karen Nelson, Brooklyn Health Home and Maimonides**,** focused on the establishment and use of a dashboard to promote communication and exchange of information. The clinical model is supported by integrated and sophisticated care management, CDS, patient engagement, ONC Direct messaging, and analytics capability, all based on a single, unified HIE process engine (GSIHealthCoordinator), or the dashboard. The dashboard supports a multi-source clinical data repository and data warehouse that provides seamless data and process integration throughout the application suite. The dashboard provides electronic interoperability with the Statewide Health Information Network for New York (SHIN-NY), exchanging patient identity management, program enrollment and consent, event notification, and longitudinal patient clinical summaries through HL7 and IHE standards-based documents (e.g., Continuity of Care Document - CCD), messages and protocols. This standards-based interoperability architecture provides users, and ultimately patients, seamless access to community-wide clinical, demographic, and event information from SHIN-NY connected providers throughout Brooklyn today and throughout New York State in the near future. The platform provides secure, seamless front-end integration among the many applications presented to users through the health home dashboard, and is capable of further front end integration with EHRs through Single Sign On (SSON) technology. The dashboard processes the data to provide real-time, actionable information to care managers and providers in a single unified care plan, which allows for the coordination of care for complex patients at care transitions and other essential points. A fully functioning version of the application optimized for secure use on mobile devices (e.g. iPhone, Android) is targeted for release in 2014. She acknowledged that adoption of the system on the part of clinical providers has been relatively slow. Part of bridging this gap is building a common understanding of the work needed for internal and external communication. The essence of this conflict is the misalignment of incentives: providers are not reimbursed for documenting their work in the dashboard. When providers do begin to utilize the system, however, they quickly appreciate the value-add that this system offers them in caring for this very complex patient population and then become champions for the system.

Hunt Blair, State of Vermont, Office of the National Coordinator for Health IT, said that he was a last-minute invitee and did not submit written testimony. He reported that state leaders are beginning to understand the need for patients' information to flow across boundaries. They see the importance of going beyond EHRs. The lines between parts of the IE system are blurring. One of the consistencies among states is that all are working on relationship transformations. States are working on links with LTPAC. In Oregon, state resources were pooled to accelerate interoperability.

John Lynch, Connecticut Center for Primary Care, ProHealth Physicians, talked about roadblocks. The National Government Services (NGS) is a roadblock for timely processing of provider credentials. Delays impact all aspects of the ACO program, according to Lynch. PECOS is a major problem for provider-supplier attribution to ACOs. The PECOS paper process may take up to 8 months. The delays greatly impact beneficiary assignments. Providers leaving a provider group may look like they are still assigned to the group for 8 months. State agency systems are unprepared to participate. The duals program will require lead care managers to coordinate with a large number of state agencies and contractors, none of which have the capability to integrate electronically with PCP EHRs, making it difficult to reconcile medications and care plans. The duals program metrics reporting process will not use GPRO, and will be state specific, meaning redundant, duplicative reporting processes. Each private payer selects different metrics, adding to the workflow challenges. Some proposed quality measures depend on hospitals (i.e. real time hospital admission notifications) that may not be part of the ACO or medical neighborhood, meaning that the ACO can be penalized for something not under its control. Some metrics are outdated – i.e. A1C and lipid medications should match updated guidelines and be adjusted by patient specific attributes and risk. The CMS Advanced Payment approach is insufficient. Larger PCP-driven ACOs not qualifying for advanced payment do not have the capital to invest in the needed systems. Shared savings, if any, come two years later. Better cash flow and sources of capital are necessary.

Q&A

Nelson said that it is challenging to determine what information is most important and which team member to prompt. Providers do use the dashboard. Front page alerts are important. In Connecticut, the concept of a community record is important, according to a panelist. In addition to information essential to the EHR, non-essential information, such as patient's transportation barriers, must be captured. There is a common repository for the sharing and use of non-essential information. Another panelist spoke about coordination of the many coordinators. They need to be able to exchange messages directly without going to the portal.

Westley Clark, Substance Abuse and Mental Health Services Administration (SAMHSA), inquired about Trygstad's comment on the need for an unambiguous definition of the substance use treatment rule. Trygstad replied that there are various interpretations, some narrow and others broad. Interpretation at the IT level is needed. Clark said that he did not understand the problem; the law is the law. He wondered who would read the new regulations, if they were changed.

In response to a question from Terrell on care coordination and the push-pull of information, a panelist explained that the repository does not always know which doctor is linked to which patient. Because of the many care coordinators involved and their inability to access all information, the information cannot be reconciled. Another panelist talked about the importance of a master person index and a provider director. They should be tagged for future development. Blair spoke about the time and effort that will be required to get all this right. Clarity about the desired end state is needed. Nelson described a pilot on insurance claims in which the insurance company is responsible for care coordination. Another panelist said that contextual information is important. The focus on population management requires a different system in order to push information to providers other than the PCP. He described a process for doing medical reconciliation by e-mail.

Regarding a question about the potential value of standardization of processes by ONC, a panelist opined that ONC's involvement disrupted private efforts on HIEs. Concentration in the industry may result in standardization and less need for HIEs. Standards to automate a care plan could be useful. But standards that inhibit future developments should be avoided. Value-based payments may be an incentive to standardize. HIEs are not needed; the internet serves the same purpose. Another member disagreed, saying that state-level data are often beneficial. Someone said that more development is needed before standards are timely. Nelson said that standards for transmission of BH data could be helpful.

Directories that include everyone, not just physicians, would be helpful, according to a panelist.

Nelson explained that NYC has done a lot to involve the non-medical services. A lot of shelters are connected to the dashboard. The addition of churches is being piloted. The consortium with its ACO-like payment structure has the power to make these changes.

How will community organizations be compensated as the switch from fee-for-service is implemented? What about bundling these services into capitation? Trygstad said that a universal definition, which is different from technical standards, is needed. For example, medical reconciliation is defined in many different ways. As care teams expand, interpretations will increase.

In Vermont, public housing sites are involved with Medicaid services in one project. Care coordinators are on site and have connectivity with providers. They are included in Medicaid payments. The project has received a positive evaluation.

Ross asked, referring to question 7, about meaningful use and benchmarks for transfer of information. Do you have faith that this will change community behavior? A panelist responded that transparency with metrics is essential. There is a need for standards that are well defined around the metrics. Transparency may drive change.

Williams, ONC, said that states have the power to improve exchange of information. What are the most exciting things being done with state policy? A panelist responded that in his state everything is being done by the private sector. Blair talked about Oregon's law for full integration beyond the medical home. States have different approaches. Someone said that ONC should capture measures from states and their different approaches and learn from them. Meaningful transmission goes beyond meaningful use; the former is essential.

A member referred to question 6, asking how to exchange information with ineligibles. Nelson reported that care managers input data directly to the dashboard. Some organizations have their own simple EHR systems. The collaborate tries to coordinate at the dashboard level.

Kevin Larsen, ONC, inquired about the factors in successfully integrating these non-medical providers. A panelist referred to context. There is a need to measure and learn from what is organically happening. Blair reported that, in Vermont, at first the system did not work well. Death registry notification was one of the first efforts. Coordinators and staffs began to see value in notifications. Meaningful use is successful. Information is being digitalized.

Panel 4: Vendors and Service Providers Enabling Accountable Care
Moderator: Karen Bell

Kris Gates, Health Endeavors, was unable to attend. She submitted written testimony.

Matt Eirich, The Advisory Board, acknowledged the many barriers to getting data from EHRs. Stage 3 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. 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 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. He testified that 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. Another suggestion is that 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. 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.

Dan Haley, AthenaHealth, described his organization's cloud platform, which coordinates across providers and geographies, tracking patients, curating and transmitting patient information, and providing granular data analysis, all of which are common in most sectors of the economy, but still relatively rare in health care. He said that many of his clients want to participate in value-based payment models like the Medicare ACO program, but they want to do so without having to become employed by a large health system. Federal policy requirements create an environment where participation in these programs requires management by a full team of administrative and business personnel, as well as tremendous technical resources, large patient panels, and data and granular insight into patient data—not resources that a small, independent practice has. According to Athena's 2013 Physician Sentiment Index, 78 percent of physicians are not optimistic about their ability to practice independently or in small groups in the future. Large systems now employ about 25 percent of physicians; employment of physicians has increased 30 percent over the past few years. He described the Independent Risk Manager (IRM) proposal as representing one possible way to fill the gap in federal policy that is inadvertently leaving small group providers behind. It would allow independent physicians to collectively share risk without forming a separate ACO entity, utilizing a health information backbone like AthenaNet to outsource the administrative and technical burden of ACO programs. By filling this policy gap, the IRM would also address the unintended consequences of the Medicare ACO program: independent physicians sharing risk will not have the perverse incentive that hospitals and large health systems have to consolidate market share and bring patient volumes in-house. Independent physicians sharing risk through an IRM or similar model will achieve cost savings for Medicare while doing well financially on their own and maintaining competition in health care. Filling this policy gap is essential, because if left unchecked, market consolidation by hospitals and large health systems will drive health care costs up, not down. He emphasized that the IRM is merely one example of the kind of innovative model that federal policy should enable, not impede. To enable such models, policymakers should focus less on prescriptive certification standards, and more on broad, outcomes-based measures to evaluate proposed new models.

Josh Seidman declared that meaningful use has set providers on the right path for new payment models—to measure performance, right-size population management investment, and reward clinicians appropriately. He said that Stage 2 will help with managing accountable care organizations. Many ACOs are structured around persons with complex needs, requiring attention to social issues. IT must incorporate social service providers and eliminate silos. Although the integration of data from different sources is essential, manageable reporting tools are also required. The goal is actionable information. 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. Data silos reinforce other 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. Overall, a very small proportion of revenue comes from value-based payments.

Q&A

With regard to what the vendor community is doing to address the problem of interoperability, Haley replied that the government is continuing to provide incentives for non-interoperable technology. Meaningful use should require interoperability. Large organizations have market-based incentives to use technology to lock patients into silos. But there is also increasing demand for interoperability. Were the government to impose standards, they could lock in obsolescence. A panelist talked about CommonWell, an industry initiative to work on interoperability across vendor platforms, which would enable patient matching and queries. CommonWell's one-year pilot is underway. ONC's Direct and Blue Button are other efforts. Eirich mentioned that incentives for vendors to integrate data are needed. Someone said that purchasers also must be incentivized.

Regarding a potential business case for HIE, Haley said that information exchange is required for going beyond fee-for-service. The big players recognize that interoperability will come. But some government policies are slowing progress, for example, the Stark restrictions on paying for information. He explained that AthenaHealth received approval to pay for receipt of information. However, it is not a sustainable business model for a single organization. He hopes that all organizations will receive an exception from the restriction. Someone referred to vendor bashing and said that he doubted that providers are really demanding IE. Eirich described working with claims data after adjudication and using the data to identify high risk patients. Both payers and providers are interested. PCPs also want to be notified about plans for surgery so that they can advice on different interventions. Someone said that although there is reluctance to share claims information, the content and structure of the information is less an issue.

Noting that ONC has partially funded several all claims databases, Bell asked whether they are helpful. A panelist indicated that having that information can eliminate some uncertainly about going into an ACO.

Frank Ross observed that the industry is not solving problems and developing products for interoperability. What policy can address this failure? Haley said that meaningful use was intended for the use of technology, beyond its adoption. Industry representatives lobby Congress, saying it is too hard and too fast. According to him, HIT can do what IT does in other industries. AthenaHealth's customers had high rates of attestation. Policy should not be adjusted to accommodate laggards. Physicians expect certified products to do what they are required to do. Another panelist talked about the need to go beyond clinical data to provide data, including BH data, to help organizations manage populations. And much of the data are not clinical. Another panelist acknowledged the power dynamic between the vendor and the customer. Before signing a contract, the customer has the power. After the contract is signed the power relationship is reversed. Warranties are an issue. The HIT Policy Committee could recommend indemnifying certain innovations. The provider is the primary owner of the data. Another idea is, rather than penalizing providers for failure to meet deadlines, to fine the vendors and require them to provide those providers who failed with the right products.

Terrell inquired about plans for big data. A panelist declared that his organization is already doing claims databases and registries. Haley said that the cloud enables big data. He tracked flu outbreaks for CDC during the shutdown. The Medicaid claims database in the largest, but its use is restricted. This is an area for policy change. A bill has been introduced to mandate opening access to it.

Concerning real time notifications, CommonWell is working on a solution. The IRM proposal is another approach.

How is data transformation working, and what about data quality? Should certification be based on minimum capability? One panelist said that there is sufficient information available to evaluate products. Providers purchase all kinds of products without certification. Another panelist suggested that policy makers can be more deliberate about the certification process and criteria. Industry can do a better job in getting up to speed with other industries. Someone else said that data quality is an issue for rectification.

What about data reconciliation and transparency about performance of tools? A panelist agreed that this is an important concern. It would be useful to have standard definitions. But developers want to protect intellectual property. The government should let the customer decide whether she is satisfied.

Ross asked Hardy whether he would be opposed to publishing the data dictionary, not the code, for his products. Hardy assured him that he is all for transparency. However, he declined to commit himself to release of the data dictionary, saying that he will answer the question later. Terrell said that according to their professional ethics code, physicians cannot withhold information about inventions that would help all patients. She wondered why this principle does not apply to vendors' technology.

Closing Remarks

Kennedy said that problems with interoperability across and within vendor platforms were described in each of the panels. Many panelists expressed the opinion that vendors could do a better job. The workgroup will discuss the information from the testimonies and form recommendations to submit to the HITPC. Terrell noted that help is needed to establish policy on information integration.

Tang spoke at length about his concerns and observations. A longitudinal shared record is needed. Not much was said about patients. Identifiers, notifications, consideration of non-medical information, and vendors building barriers were frequently mentioned. Content standards were frequently noted as an issue. He acknowledged the difficulty of knowing what to do policy wise. Although he asked panelists about policies to rectify the problems they described, their answers were not good ones. He opined that there are enough standards to get started, but the human factors are missing. Perhaps the governance model should be reconsidered. Organizations need a way to operate with each other. Perhaps Stage 2 qualification should be a condition for ACO participation. There was no discussion of measures that matter.

Discussion

Kennedy asked that the slide listing the meeting objectives be shown. He admitted that he was surprised about the difficulties experienced with even the basics of information exchange. Problems with vendors are paramount. Terrell said that the one who owns the data has the advantage. Access to risk information is essential for financial modeling. Tang reminded them that the panelists are early adopters.
Since the future is not clear, it is difficult to know how to prepare and how to make things clearer.

Regarding bright spots, a member mentioned the physician panel on presentation of data from claims and statewide claims. Bell observed that large, well-integrated groups that have been doing this for some time have figured it out, but start-ups with upside risk are having a difficult time. CMS could work on harmonization across payers and find ways to deal with the burden.

Someone acknowledged that there must be a compelling business case. The 30-day window may create a case.

Another member observed that the testimonies were realistic. He acknowledged that he had had low expectations. If an organization takes risk, it must completely understand what is happening. Much of the IT technology focuses on internal improvements. ADTs are trigger points for safety and cost. The technology is not that complicated. Someone said that he was surprised that the panelists were not impressed with the notification of non-medical providers in Cincinnati.

A member said that many hospitals simply do not want to share information. It would be politically difficult for CMS to change this by regulation. Tang reminded them that the Stage 3 draft requires notification of events.

The federal government can do something about payments across state boundaries.

Turning to the first meeting objective, they heard from almost every panelist that information cannot be integrated. Silos are purposefully constructed. The vendor is the problem. Databases must be opened. Many of the meaningful use mandates have gone nowhere. There is no market. The vendors cannot be changed. No one likes the way information is being held hostage. There are many ways to get data in addition to exchange.

Obtaining and sharing information on admissions, discharges, and transfers is critical. The panelists did not talk about pharmacies; better information on whether patients picked up prescriptions and of how many pills is needed. A member related her experiences with changing vendors, declaring that although difficult, it can be done.

Bell acknowledged that she did not sufficiently explore modular certification in her panel. She offered to follow up via telephone. Can certification or the loss of certification be used when vendors do not provide on-going service? Monitoring of these vendor-related issues should be on-going. Regarding the suggestion that incorporation of claims data be a criterion for certification, Bell indicated that incorporation of claims data can be done without an EHR. Someone complained again about experience with Epic, saying that his Epic representative told him that it owns the database and that data from another source cannot be incorporated in it.

Someone pointed out that ACOs are now an interest group with their own association.

Kennedy said that he did not hear much pertaining to the fourth meeting objective. Someone said that only large organization have the capital for the necessary infrastructure.

The workgroup will meet on December 13 to continue the discussion.

Public Comment

Katie Boyer, HIMMS, requested that the members read her organization’s written testimony.

Hearing Materials

- Agenda
- Panelists Bios
- Presentation slides
- Questions to panelists
- Submitted written testimonies