Accountable Care Workgroup Discussion Themes
*DRAFT - September 19, 2013*

The thirteen themes listed below have emerged from discussions of the Accountable Care Workgroup related to the comprehensive set of functions described in the “Health IT Framework for Accountable Care” prepared by CCHIT. These themes align with three overarching criteria for HIT capabilities that:

1. Are critical for entities operating under accountable care arrangements to meet cost and quality targets.
2. Require near-term investment and attention from entities participating in accountable care arrangements
3. Warrant further exploration of federal policy intervention or support given prevailing market conditions.

The Workgroup has identified the these themes as major areas of opportunity for advancing success in various accountable care arrangements as participating providers seek to achieve required cost and care quality targets. While many of these capabilities may be obtained today with significant investment, the Workgroup seeks to ensure that these capabilities are available broadly in the marketplace so that organizations can more rapidly adopt the value-based payment structures which are critical to delivery system reform.

Preliminary policy discussions of the Workgroup surfaced specific policy areas for further exploration, which are presented below each of the key themes.

1. **Increase availability of/access to information about patient functional status.** In order to proactively improve patient outcomes and satisfaction, accountable care arrangements need access to a richer set of standardized data around the functional status achieved through different interventions.
	1. ONC should consider purchasing a universal license for some standardized clinical assessment tools (subsets of an SF-36, for example) or create and validate some that can be used to determine how well patients are truly functioning within their environment and whether or not specific interventions have proven useful for those individuals. Functional assessment tool and standards are being developed by TEFT program but workgroup could assess whether there is a need for a common standardized global patient assessment like a HRA that could be enabled through certified HIT.
	2. Facilitate integration of data from home point of service labs and biometric monitoring equipment into HIT applications to provide information about interactions with patients in a non-traditional setting. Consider overlap with the current goals of the FDASIA workgroup.
	3. Promote development, validation and provision of standardized patient derived outcome measures.
2. **Facilitate robust information sharing among care team members and other providers involved in patient care.** To deliver care coordination that is patient-centric and coordinated across providers working together under an accountable care arrangement, care team members need access to more robust tools for collaboration. As the care team grows and other stakeholders such as payers seek to partner around care delivery, accountable entities will need to ensure there is clear delineation of who is providing which services to the patient, communication between parties, and that services are provided in an effective manner.
	1. Advance work around a standardized shared care management plan beyond today’s care summary record standard. Consider how tools such as a “wiki-like” care plan could work in a variety of settings with a virtual care team. Consider current care plan standard being balloted by HL7 and understand if this work needs to be further expanded.
	2. To avoid duplicative tracking, explore ways to confirm that a given order accomplished what it was intended to accomplish, rather than tracking each individual order, which is challenging across multiple EHRs.
	3. ONC should continue to advance work toward developing a more structured longitudinal record accompanied by a lightweight wrapper to enable portability of data from one provider to another, or one EHR to pre-populate a registry or warehouse.

1. **Enhance cohort identification and management tools within EHRs or other HIT applications.** Clinicians’ ability to conduct population health management tasks on their own patient populations is critical to operating within an accountable care arrangement, yet market offerings that offer these capabilities in a seamless, user-friendly manger have yet to mature.
	1. Explore how modular approach to HIT certification could ensure adequate population health management/registry functions in a spectrum on HIT products that would be used by ACOs.
2. **Enhance capacity to conduct organization-based CDS.** Consortia of providers operating under accountable care arrangements need effective ways to customize clinical decision support to individual patients based on identified priority areas for intervention.
	1. Enable organizations’ to send messages that are computable within clinicians EHRs at the point of care based on care gaps identified or findings for a given patient.
	2. Explore ways to enhance CDS capabilities developed within the organization as opposed to commonly accepted EBM. May only be of interest to large ACOs but those who can do it will have a significant edge on their competitors.
	3. Explore ways to match interventions with information contained in engagement assessments.
3. **Improve effectiveness of CDS tools.** Effective use of clinical decision support tools are a major focus for accountable care arrangements seeking to ensure clinicians are adhering to EBM. Current offerings continue to suffer from usability challenges and are unlikely to help providers achieve consistent changes in practice.
	1. ONC should explore ways to support effective CDS through a set of metrics that would guide rigorous tuning of alerts to maximize safety yield and actual behavior change. These metrics could measure the yield of an alert, including the time an alert is open and whether the action recommended was taken.
4. **Increase availability of coverage information for clinicians.** Providers in accountable care arrangements responsible for the total cost of care of populations need to be able to factor in coverage and cost information as part of referral decisions in order to reduce friction and blind ends that result from trying to match up coverage services with accepting providers.
	1. Enable clinicians to view health insurance coverage information in real time.

1. **Increase availability of real-time alerts for patient care received across all settings.** The “leakage” challenge is a major business issue for organizations operating under accountable care arrangements. ACOs need seamless access to alerts of their patients’ external care encounters in order to intervene and direct them to appropriate choices. From the Workgroup’s perspective, alerting is a vitally important function for health information exchange platforms.
	1. Explore ways to enhance/spread role of HIEs in providing this service.
	2. Explore ways to increase access to real-time information related to Hospital, SNF, Rehab admissions, Part D claims fill, and ED/Urgent Care visits.
	3. Consider incentives as part of Pioneer ACO contracts or Shared Savings contract for particular functions that require HIE enablement.

1. **Encourage patient engagement with the healthcare system.** Organizations operating under accountable care arrangements need to implement a variety of strategies and services to encourage patients to easily access appropriate services.
	1. Scheduling online (not request) is a critical step in administrative simplification for patients which may develop without intervention given experiences in other industries, but a nudge would help.
	2. CMS should explore ways to promote patient ownership by using patient compliance data to increase costs or reduce costs for patient contribution based on patient compliance with treatment care plans.
	3. HHS should consider ways to improve information resources for patients and manage those resources.
	4. Rather than focus on the presentation and delivery of information, HHS should focus on assessing the objectivity of information made available to patients.
2. **Increase provider insights into financial metrics/cost data.** Providers operating under accountable care arrangements require tools that can provide more transparency into costs and enhance business intelligence around costs associated with specific patients and treatment.
	1. Explore ways to support models in financial metrics/reporting/predictive analytics are delivered by a third party to ensure smaller groups of providers with limited resources are able to effectively participate in risk-based arrangements.
3. **Increase Availability of Claims Data.**
	1. HHS should support development of maintenance of APCDs in every state where Medicaid is developing ACOs so that the data can be used for case mix adjustment, attribution algorithms, bundled payments, total cost calculations, determining leakage, and program evaluation.
	2. Explore other ways to underscore the importance of and expand existing efforts in states that have built or are building all-payer claims databases, particularly in encouraging databases which offer identified data suitable for attribution (as opposed to deidentified databases).
	3. Explore levers to link claims databases with clinical data in health information exchanges.
4. **Increase ability to analyze integrated claims and clinical data.**
	1. Encourage the development of cohort identification algorithms that can run on integrated clinical and administrative data.
	2. Trusting the metrics around utilization or the performance metrics is challenging for both payers and providers engaged in risk-based contracts. Explore ways to encourage trusted third-party arrangements which allow both parties to have confidence in measurement.
5. **Simplify and clarify methods of patient attribution under accountable care arrangements.** Currently there are a wide range of approaches, but movement toward consistency and more simplicity would be beneficial to organizations in accountable care arrangements. Smaller, physician-led ACOs which are less likely to have the resources to establish infrastructure across multiple data sources.
	1. Encourage simplification of attribution algorithms to assign patients to different accountable care contracts/calculate shared savings.
	2. Consider ways to encourage best approaches to developing attribution algorithms on an APCD. To really manage care we are going to need to move from post hoc attribution for payment, toward explicit assignment of responsibility to members of the care team.

1. **Enhance interoperability of systems to share clinical information.**
	1. Address current interoperability gaps by requiring certification processes around both sending and integration/digestion of information. Policy should address standards for messaging, data collection, and data incorporation within a patient’s record to ensure applications are robust. Require vendors to submit to compliance testing that demonstrates the technical ability to not only send and receive but make the data computable with other systems.
	2. Encourage additional innovation around natural language processing, which is currently being explored by vendors. Area may not be mature enough to warrant inclusion as core criteria, but recognizing semantic interoperability as an optional or menu requirement could convey to the vendor community additional urgency.