*HIT Policy Committee Feedback on ACWG Draft Recommendations – April 8, 2014*

* The “business imperative” criteria discussed point to issue when there is a business imperative for the user, but not a business incentive for the vendor. Major problem to solve is how to create a business incentive other than through regulation that imposes significant costs on vendors. (Judy Faulkner)
* Recommendation 4.C (“Develop future certification criteria to promote access to EHR data by other types of HIT systems to support population health management, operations, financial management, and other uses”)is very interesting—need further thinking about whether this is the CCDA or more than that? Is it allowing third parties to request the data set for individual patients? Is a third party sending a query? Is it third parties requesting a query or is it sending over information into another database? Need to understand safety and feasibility issues across different ways to approach this. (Judy Faulkner)
* Concerned when messaging about care plans suggest that they are not well-defined, when the care plan is foundational to the practices of inter-professional teams. Need to make sure to get input from nursing experts and other care team roles who are deeply engaged with care plans in discussions to inform the HITPC and any other workgroups addressing this issue. (Troy Seagondollar)
* Accountable care movement is largely being driven by payers and purchasers, and it will continue evolving in ways that we can’t foresee. One of the challenges we have is to figure out how to go back into the EHR and the certification program and essentially update it to accommodate emerging requirements for information that cover the continuum and that reflect outcomes and continuity of care across the different sectors and silos. (David Lansky)
* Recommendation 6.B (“Articulate HHS’ future strategy around the infrastructure needed to integrate claims and clinical data to support accountable care”) is key--highlights the need to integrate clinical data with real time cost and resource information. However, we should broaden this to be not just about claims, but about cost and price data in order to emphasize the real time nature of what is needed to be successful. (David Lansky)
* Both recommendation 2.E (Drive progress on standardization and capture of social determinants of health data elements that are most critical to accountable care delivery models”) and 4.C (“Develop future certification criteria to promote access to EHR data by other types of HIT systems to support population health management, operations, financial management, and other uses) point to the need to think about a data network rather than the EHR as the focus of attention. We need to broaden our lens and think about a data network with a variety of nodes that gets to more of a patient centered view of the network, beyond what is covered by the Meaningful use program. (David Lansky)
* We shouldn’t just be thinking about building a longitudinal record layer on top of a bunch of EHRs—we also have to look at the capabilities of current EHRs to capture and aggregate social and clinical data to support an episode of care and accountable care models. (David Lansky)
* Current quality reports are not quality reports, but penalty reports used by payers as a reason not to pay for a service. ACOs promise to deliver quality reports that are integrated in the real-time daily activities of providers. (Paul Egermann)
* Concern about the lack of EHR vendor representation on the group relative to discussion about “business imperatives”. (Paul Egermann)
* Notification process called out in recommendations is critical for providers, this is very important for providers in real time to understand where their patients are going and what’s happening to them. (Neil Calman)
* Capturing more data on social determinants is also a critical piece because getting out of the medical model and understanding the range of issues impacting patients is a priority for ACOs. (Neil Calman)
* We should be cautious not to put any further requirements on providers around their participation in ACO. While requirements around meaningful use may be OK, we need to think carefully about anything beyond that. (Neil Calman)
* Recommendations around making all claims data available for a given patient raise privacy concerns. Patients don’t want providers to have access to every instance of where they have touched the health care system. Moreover, patients aren’t choosing to be in commercial ACOs. Need to have some tradeoff between using this data to manage costs and privacy expectations of patients; the claims “record” needs to be subject to the same sorts of privacy concerns that the EHR has been. Potential area for Privacy and Security Tiger Team attention. (Neil Calman)
* Recommendation 4.D (“Increase availability of data from remote monitoring devices to engage patients more deeply in their care”) brings up lots of interesting privacy issues around the question of data from remote monitoring devices—devices collecting daily behavioral information about your activities may present even deeper privacy issues than access to basic records. Potential area for Privacy and Security Tiger Team attention. (Dave Kotz)