**Key Messages/Takeaways from Accountable Care Workgroup Hearing**December 12, 2013

**Key Messages**

1. **Data integration across EHR systems continues to be a major challenge for providers partnering under accountable care arrangements.** Providers repeatedly highlighted this as hindering their ability to integrate care across networks. So far, ACOs do not appear to have the purchasing power needed to influence vendors to solve the interoperability problem.
2. **Reluctance to share data across providers is an ongoing challenge for care coordination.** Incentives persist for large medical groups including ACOs to maintain data silos as a key competitive advantage. This status quo is a significant drag on the capacity to realistically coordinate care across settings, and we should consider the ethical implications for patient care in prioritizing a response.
3. **At this stage, most organizations are focused on a discrete set of common strategies to succeed within accountable care arrangements.** Most ACOs are still in the early stages of understanding how to succeed within value based arrangements but early common strategies include increasing coordination between inpatient and emergency facilities and ambulatory settings.
4. **Many providers are using health IT solely to meet requirements, rather than as a means to support new models of care.** Despite adoption of systems, there are stillmajor gaps to making information meaningful to clinicians; human interpretation and action is often the critical missing piece in making effective changes to care delivery.
5. **We need to distinguish between tools for encounters (the traditional focus for EMRs) and tools for population health, which by definition take place outside the encounter.**
6. **HIEs are solving the interoperability problem in select markets, but sustainability and spread challenges are a major concern.** Even in areas with significant HIE coverage, interoperability between HIEs remains challenging and supporting multiple HIEs is not feasible for many providers.
7. **There is ongoing lack of clarity around the key measures that are needed to drive care improvement within ACOs.** Many providers do not see quality measures as critical to care but solely as a vehicle for reporting. Understanding of the right measures to drive improvement is still nascent.
8. **ACOs need to do more to prioritize a patient-centered approach to care and identify common HIT strategies for engaging patients in their care.**
9. **Technology solutions need to serve the care team, not just physicians.** ACOs are focusing on expanding the care team MPI and provider directories, all these other community entities, they are not the physician all the time, need to be incorporated into the standard
10. **Smaller organizations unable to meet the administrative burden and IT requirements of value- based payment models are going to be challenged by the broader market shift to value.** Programs such as CMMI’s Advanced Payment are seen as a critical way to address this disparity but more attention/consideration of the problem is needed.

**Suggested Strategies/Actions**

*This is a partial list of strategies and associated suggested actions described during the December 5th hearing of the Accountable Care Workgroup.*

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| **Strategy** | **Suggested Specific Actions** |
| 1. Advance governance activities to support data sharing across partners. | * 1. HHS should target markets which should have significant accountable care penetration but are not moving forward on interoperability and convene leaders to pursue agreement around exchange. |
| 1. Incentivize data sharing through the Meaningful Use incentive/penalty structure. | 1. Waive payment adjustment penalties to doctors that replace non-compliant EHRs with compliant EHRs. |
| 1. Impose additional interoperability requirements on vendors through the Meaningful Use certification framework. | 1. Develop a mechanism to revoke certification from EHRs unable to effectively exchange data with other systems. 2. Require EHRs to publish their data dictionaries. |
| 1. Establish additional data sharing requirements in the Medicare Shared Savings Program. | 1. Require participating MSSP organizations meet a transitions of care measures using CHERT for a majority of provider network. |
| 1. Establish additional data sharing requirements in federal programs to drive interoperability. | * 1. HHS could add data sharing requirements to readmissions penalties program.   2. Leverage incentives through Medicaid 90/10 funding.   3. HHS could heighten expectations in the market of future prescriptive action if more progress on exchange from providers is not forthcoming, through rulemaking language, etc. |
| 1. Identify and validate basic capabilities around data aggregation and analytics tools to promote transparency in the market for population health tools. | 1. Develop additional “voluntary” meaningful use certification requirements for population health management functions (in EHRs or other applications). |
| 1. Enable spread and adoption of dashboard functionality to support care team management of populations. | 1. Opportunity to explore supporting this functionality through meaningful use. |
| 1. Make claims data available at the point of care needs to be available to providers and patients to inform decisionmaking and reduce costs. |  |
| 1. Promote integration of providers across the continuum of care including facilities ineligible for MU incentive payments. | 1. Explore incentives for home health, SNFs, etc. to use EMRs that push at least ADT information, as well as other information including labs, etc. |
| 1. Develop and spur adoption of actionable metrics that help ACOs drive improvement. | 1. Bundle measures around a disease process. |
| 1. Advance the development and utility of all-payer claims databases to support cost management by ACOs and provide up-front market intelligence to organizations considering entering into value-based arrangements. |  |
| 1. Enable adoption and spread of shared, longitudinal care plans to support patient-centered care across disparate organizations. | 1. Address common policy issues around longitudinal care summaries which are unclear today, e.g. who curates the information and who has rights to the summary, how to determine role-based access, role of the ACO, etc. 2. Develop standards for patient event notifications (existing work planned in Meaningful Use Stage 3 around transitions of care documentation). 3. Leverage Meaningful Use payment structure to incentivize provider collaboration around shared care plan. |
| 1. Promote the scale and spread of patient event notifications to notify ACOs when patients access acute care services and providers outside their network. | 1. Establish standards for patient event notifications (Meaningful Use Stage 3 to include standards). |
| 1. Make behavioral health/substance abuse claims data available to ACOs to support integration of behavioral health and primary care and management of high-risk patients. |  |
| 1. Promote more clarity around legal restrictions around sharing sensitive data; variable interpretation of law across states and providers is hindering exchange. |  |
| 1. Promote “untethered” patient portal solutions on a community wide or ACO-wide basis to improve uptake and adoption by consumers. | 1. Address VDT requirements in Meaningful Use stage 2 driving proliferation of tethered portals to meet requirements (planned for inclusion in 2015 edition certification criteria). |
| 1. Promote availability and exchange of data on “social determinants of health”/non-clinical data critical to managing high-cost patients. | 1. Ensure these data are included as part of longitudinal care record standards. |
| 1. Address prospective assignment practices in ACO programs which hinder organizations’ ability to match a numerator to a true denominator and calculate accurate measures of cost and quality for attributed populations. |  |
| 1. Enable adoption and integration of remote monitoring devices ACOs are using to manage high-risk patients in the home. | 1. Establish standards that will allow remote monitoring devices to exchange data seamlessly with EHRs and other platforms (private entities including West Wireless and Continua Alliance are exploring standards). |
| 1. Address standards challenges around ICD 10 implementation. | 1. Task NLM with creating a reverse map of ICD-10 to SNOMED. |
| 1. Address negative effects of transaction fees charged by vendors on exchange, e.g., providers limiting exchange to only meet the meaningful use requirement. | 1. CMS should explore avenues to assume costs of fees paid to EMR vendors. |
| 1. EHRs should be able to extract “facts” from received claims and HL7 Consolidated-CDA documents (e.g. Test results, immunizations and visit notes) and automatically incorporate them into the EHR as discrete data. |  |