Health IT Policy Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

# Advanced Health Models and Meaningful Use Workgroup

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# Agenda



I. Overview
II. Health IT and Certification in Support of Alternative Payment Models (Audacious Inquiry)
III. Workgroup Reactions
IV. Health IT Policy Committee Feedback and Comments

# Health IT and Certification in Support of Alternative Payment Models

# Health IT and Certification in Support of APMs

## Research Goal and Framing Considerations

**Goal**

**Help ensure that the health IT capabilities that providers need to be successful in Alternative Payment Models are broadly available.**

**Framing Considerations**

- **Alternative Payment Models**… ACOs, bundled payments, PCMH
- **Timeframe**… Capabilities that need to be available by January 2019
- **Scope**… Focused on the technology, not staffing
- **Technology Types**… Health IT beyond EHRs
- **Levers**… Market forces, certification, comparative tools

# Literature Review and Interviews - Summary Findings

**State of the Market** **Interviews**

- ❑ **Programmatic Complexity:** APMs involve multiple programs from government and private payers across a wide range settings. It is challenging to define core requirements across all programs and participants.
- ❑ **Multiple Health IT Products, Modules, and Users**: Capabilities to enable implementation span multiple products and vendors and the locus of care management and users of APM tools varies across settings.

**Key Challenges**

- ❑ **Data Exchange**
- ❑ **Data Deluge**.
- ❑ **Data Reporting**.
- ❑ **Tools to Automate Management and Coordination**..

**Care Coordination** **Literature Review**

- Exchanging Summary of Care Record (including progress notes)
- Filtering and highlighting components of Summary of Care Record
- Sorting/filtering notification and alerts regarding patient ADT
- Managing referrals, including tracking status of appointments and closing the loop

**Cohort Management**

- Empaneling patients to entire care team
- Accessing a dynamic electronic care plan that helps the care team quickly get up to speed on a patient's status and agree on goals

**Patient & Caregiver Relationship Management**

- Addressing patient frustration with managing multiple portals

**Clinician Engagement**

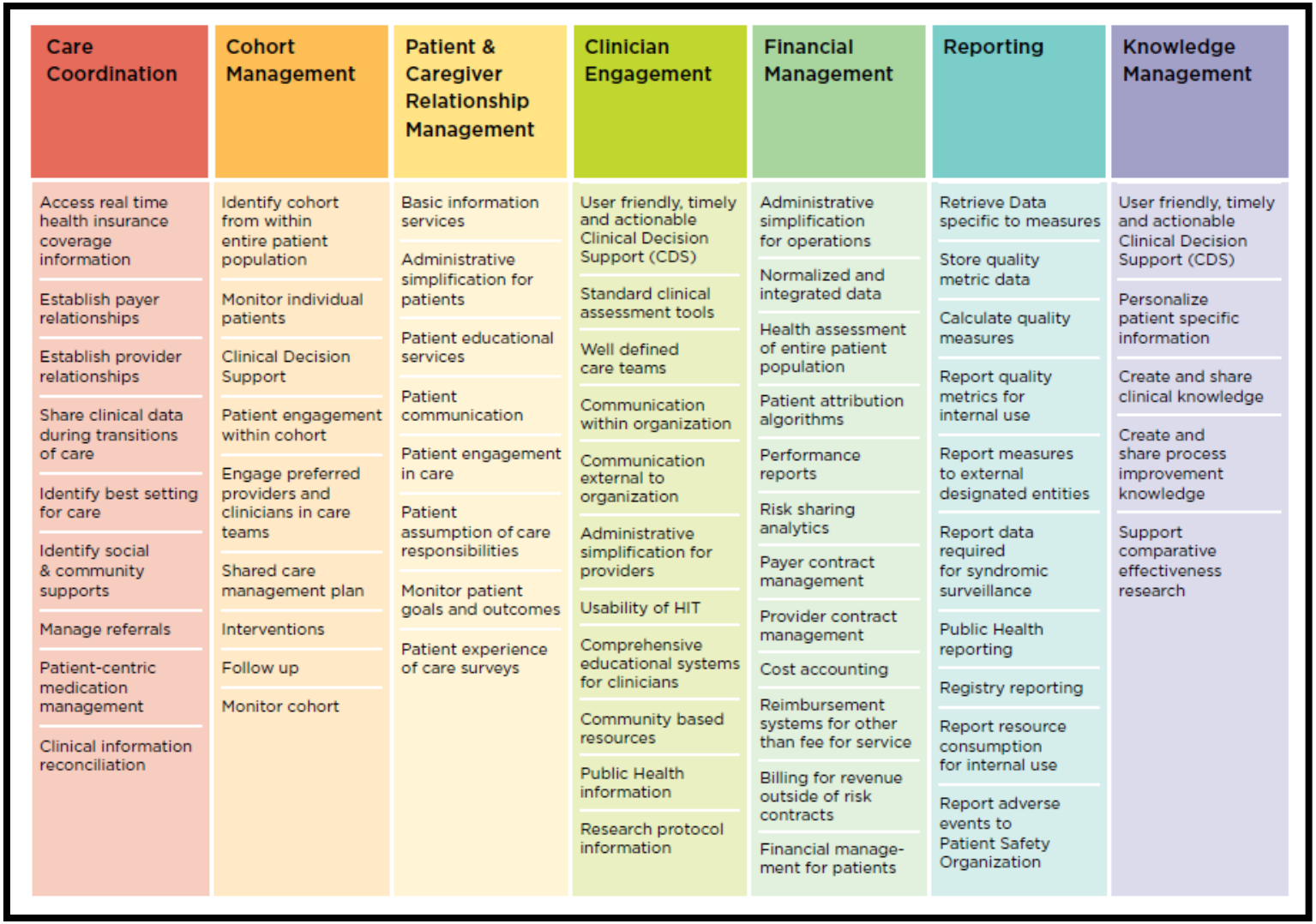
- Integrating risk stratification information into the workflow and updating as needed

**Reporting**

- Getting appropriate and accurate quality measures from systems

# Framework for Health IT in Support of APMs

## Processes, Functions, and Capabilities



| Care Coordination | Cohort Management | Patient & Caregiver Relationship Management | Clinician Engagement | Financial Management | Reporting | Knowledge Management |
|---|---|---|---|---|---|---|
| Access real time health insurance coverage information | Identify cohort from within entire patient population | Basic information services | User friendly, timely and actionable Clinical Decision Support (CDS) | Administrative simplification for operations | Retrieve Data specific to measures | User friendly, timely and actionable Clinical Decision Support (CDS) |
| Establish payer relationships | Monitor individual patients | Administrative simplification for patients | Standard clinical assessment tools | Normalized and integrated data | Store quality metric data | Personalize patient specific information |
| Establish provider relationships | Clinical Decision Support | Patient educational services | Well defined care teams | Health assessment of entire patient population | Calculate quality measures | Create and share clinical knowledge |
| Share clinical data during transitions of care | Patient engagement within cohort | Patient communication | Communication within organization | Patient attribution algorithms | Report quality metrics for internal use | Create and share process improvement knowledge |
| Identify best setting for care | Engage preferred providers and clinicians in care teams | Patient engagement in care | Communication external to organization | Performance reports | Report measures to external designated entities | Support comparative effectiveness research |
| Identify social & community supports | Shared care management plan | Patient assumption of care responsibilities | Administrative simplification for providers | Risk sharing analytics | Report data required for syndromic surveillance | |
| Manage referrals | Interventions | Monitor patient goals and outcomes | Usability of HIT | Payer contract management | Public Health reporting | |
| Patient-centric medication management | Follow up | Patient experience of care surveys | Comprehensive educational systems for clinicians | Provider contract management | Registry reporting | |
| Clinical information reconciliation | Monitor cohort | | Community based resources | Cost accounting | Report resource consumption for internal use | |
| | | | Public Health information | Reimbursement systems for other than fee for service | Report adverse events to Patient Safety Organization | |
| | | | Research protocol information | Billing for revenue outside of risk contracts | | |
| | | | | Financial manage-ment for patients | | |

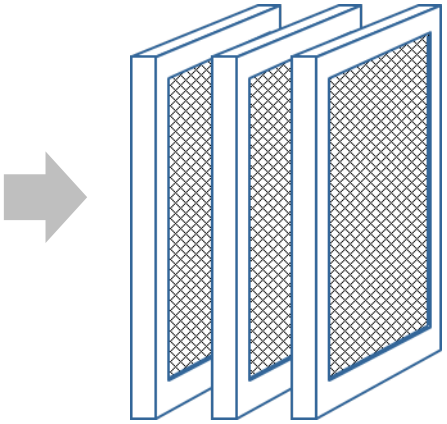
CCHIT Accountable Care HIT Framework | ©2013 CCHIT

# Framework for Health IT in Support of APMs

## Making a Manageable List

| A |
|---|
| CCHIT Function |
| 1. Care Coordination |
| Access real time health insurance |
| • Info on eligibility |
| • info on provider networks |
| • info on co-pays & deductibles |
| Establish payer relationships (collaborative case management) |
| • include plan case managers |
| • allows direct patient –specific communications |
| Establish provider relationships |
| • preferred provider lists available |
| • ability to cross-reference all types of providers & facilities |
| • ability to share clinical data among preferred providers |
| • receive notification of patient encounters w/in 24 hours of occurrence |
| Share clinical data during transitions of care |
| • auto-populate summary document at time of transition |
| • acknowledge receipt of transmission |
| • identify person responsible for follow up |
| Identify best setting for care |
| • assess acuity care necessary for transition using validated tools |
| • record/display patient & family needs & circumstances |
| • present benefit & health plan provider network information |
| • access real-time info on available beds, personnel for appropriate setting of care |
| Identify social & Community supports |
| • access list of patient designated zip codes |
| • maintain current list of community services within each zip code |
| • include patient safety risk assessment of the home environment |
| Manage referrals |
| • schedule care with preferred providers as clinically appropriate and consistent with health |
| • send clear indications for referral & requested recommendations |
| • receive, incorporate and acknowledge referral recommendations |
| • receive notification if the referral is not kept |
| • communicate with patient after referral is completed |
| Patient-centric medication management & reconciliation |
| • access med list from multiple sources & display together |
| • highlight duplication, possible duplications, & multiple meds in same class |
| • incorporate patient-supplied history re: active medications |
| • designate, date and sign reconciled med list |
| • ensure active medications & allow discontinued meds to be removed |
| • maintain list of previous meds |
| • eMAR in the inpatient setting |
| • evidence that prescription was filled or not |
| • real-time alerts when prescribing meds, discontinuing a critical med, etc. |
| Clinical information reconciliation |

**Original CCHIT List of 7 “Processes”, 64 “Functions” and 270+ “Capabilities”**



| # | CCHIT Category | CCHIT Function | Certification Aspect | Gaps | Reason for Exclusion | Relative Rank for Need in Marketplace | Needed Capabilities based on Lit Review | Needed Capabilities based on Interviews (Provider, Vendor, CMS) |
|---|---|---|---|---|---|---|---|---|
| 1 | Establish provider relationships | Preferred provider lists available | Could potentially be accomplished with a criteria for health IT to be able to query a provider directory using the HPD standard. | Gap - could be addressed through provider directory | | High | | Yes (6 respondents): Care Management: Empanel patients to entire care team |
| 2 | Establish provider relationships | Ability to cross reference the organization's preferred providers to patients' provider networks | Could potentially be accomplished with a criteria for health IT to query NPPES using the HPD standard, assuming NPPES will include the provider info from the health plans' as-was recently requested. | | | High | | Yes (6 respondents): Care Management: Empanel patients to entire care team |
| 3 | Share clinical data during transitions of care | Identify person responsible for follow up | First, would need to update the C-CDA Care Plan template to include this person. Then certification would need to require the Care Plan, which is currently optional. | Gap: Referral management possible, standard possibly 3600. | | High | Yes (2 reports): Care Coordination: Tools to close the referral loop | Yes (6 respondents): Care Coordination: Tools to close the referral loop |
| 4 | Cohort Management (population health) | Extract data from multiple sources: all payer claims, practice management, EHRs, health risk assessments | Certification criteria exists, but this would require a level to encourage non-EHR products to be certified. | Gap is not technology if it's the driver for these systems to get certified, which doesn't exist | All payer claims databases are unable to be certified | Moderate | Yes (1 report): Care Management: Integrating claims data to better detect patients at varying levels of risk | Yes (3 respondents): Care Management: Integrating claims data to better detect patients at varying levels of risk |
| 5 | Cohort Management (population health) | Apply predictive modeling algorithms to identify high risk patients | Certification criteria could include use of QUICK to access CDS services that would apply these algorithms to patient data. This would require that the API criteria be modified to include QUICK in addition to C-CDA | Gap: APIs address access to data, but unclear on whether algorithms would be certified | | High | Yes (0 reports): Care Management: Effective Risk Stratification Tools | Yes (7 respondents): Care Management: Effective Risk Stratification Tools |
| 6 | Monitor individual patients | Manage & present data in multiple usable formats (graphs, charts, etc.) including trended info | Certify the ability of a health IT product to create charts and graphs on demand based on numeric data in the patient's chart. Certification could also incorporate a time component, i.e. numerical data over time, such as BMI, HbA1c levels, blood pressure, etc. | Gap: No graphs | | Moderate | Yes (3 reports): Care Management: Improved System Usability | Yes (2 respondents): Care Management: Improved System Usability |
| 7 | Engage preferred providers and clinicians in care teams | Identify providers by specialty, commitment to care coordination, patient preference, patient's health plan | This can be partially solved by including the ability to query a provider directory using the HPD standard in certification. | Gap: Standard for query is in process | | High | | Yes (6 respondents): Care Management: Empanel patients to entire care team |
| 8 | Engage preferred providers and clinicians in care teams | Identify patient & authorized family members on the care team, including escalation path for | First, the C-CDA Care Plan template would need to be updated to require this segment, than certification would need to make the Care Plan criteria required. | Gap: Optional in the Care Plan template | | High | | Yes (6 respondents): Care Management: Empanel patients to entire care team |
| 9 | Engage preferred providers and clinicians in care teams | Facilitate communication among team members using multiple modalities | Certify real-time communication capabilities, such as instant messaging or text messaging. Could require that health IT products be able to exchange real-time messages using secure internet standards | Partial gap, we don't currently certify secure text messaging. | | High | Yes (2 reports): Information Exchange: Exchange of Summary of Care Record (including progress notes) | Yes (7 respondents): Information Exchange: Exchange of Summary of Care Record (including progress notes) |

**“First Pass” Filtering Removed…**

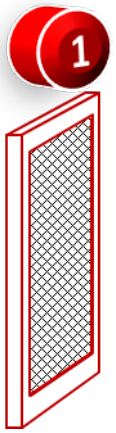
1. Administrative functions
2. Functions ranked “not critical” to providers participating in APMs based on literature review and interviews
3. Functions included in the 2014 and 2015 Editions

**Candidate List of Capabilities**

- ❑ 20 capabilities
- ❑ Additional capabilities could be considered

# Health IT Capabilities in Support of APMs

## Rating the Capabilities




**1. Criticality of the health IT function/capabilities for providers' successful performance in APMs**

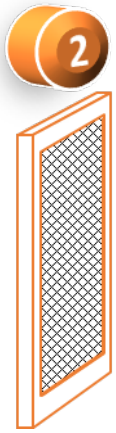
5= very important

4= important

3= moderately important

2= of little importance

1= unimportant




**2. Gap between the ideal and current level of availability & use in the market**

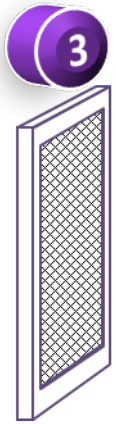
5= very large gap

4= large gap

3= moderate gap

2= small gap

1= no gap




**3. Gap in the integration of the capability in providers' workflow**

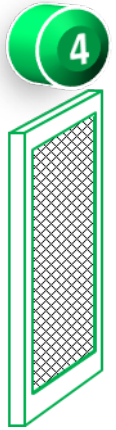
5= very large gap

4= large gap

3= moderate gap

2= small gap

1= no gap




**4. Likelihood that the Market will close the gap by 2019 w/out certification**

5= very likely

4= probable

3= possible

2= doubtful

1= very unlikely

# Health IT Capabilities in Support of APMs

## Ranking the Capabilities

1. **The Care Plan (11 capabilities)**. Enable a "dynamic" care plan that: (1) is broadly accessible to the entire care team; (2) defines and tracks accountability; and (3) monitors goals and milestones.

2. **Referral Management (2 capabilities)**. Ensure referral systems can : (1) identify individuals who are responsible for tasks and (2) integrate provider lists into the referral process.

3. **Multiple Communication Modalities (1 capability)**. Valued capability, relatively significant gap in the market that marketplace will likely cure without certification. Cautions regarding misinterpreted messages and patient safety.

4. **Notification of Test/Intervention Results (1 capability)**. Discussed the need to alert not only ordering provider, but the provider with accountability as well.

5. **Data Extraction in Standardized Format (1 capability)**. Important capability that speaks to basics of interoperability.

6. **Risk Stratification (2 capabilities)**. An important and foundational element for effective care management, but three of the eight TEP panelists indicated the market gap was moderate to small; moreover, 50 percent of the panelists believed that the market would cure the gap by 2019.

7. **Quality Performance Measures (1 capability)**. Storing quality metric data of limited value and relatively small gap in the marketplace.

8. **Data Visualization (1 capability)**. Lower relative importance and many applications exist in the marketplace, and any gaps will likely be addressed by the marketplace by 2019.

# Health IT and Certification in Support of APMs

## Assessing Certification Readiness

**Category A: Capability Requires New Certification Criterion & Criterion is Mature**
There exists a viable standard to certify against.

**Category B: Capability Requires Changes To Existing Certification Criteria**
There exists a viable standard to certify against, but its use is "optional" in current certification.

**Category C: Capability Requires Maturation Of Potential Standard/Function**
There exists a preliminary standards or functions to certify against, but requires additional maturation needed to be ready for inclusion in a certification program by October 2016.

**Category D: Capability Would Require Development Of Potential Standard/Function**
No standard or functional expression currently in pilot. Significant work required in order to be ready for inclusion in a certification program by October 2016.

**Category E: Standard Exists, But Policy Lever or Demand Needed for Certification to Have Impact**
The certification criteria already exists, but requires a lever to get non-EHR products to certify.
For example, data exports from non-EHR sources.

# Health IT and Certification in Support of APMs

## Workgroup Observations and Feedback



**Observations**

- The HIT challenges identified in the Ai analysis were generally consistent with AHM Workgroup participants' experiences – particularly through the APM provider perspective.
- The importance of effective closed loop referral management and the role of the care plan resonated strongly and dovetailed with workgroup discussions of the interoperability roadmap
- To be successful, the workgroup noted that APM providers will need to:
  1) integrate information from a broad and widening array of sources,
  2) navigate new relationships and priorities, and
  3) define and track shared responsibilities among an expanding scope of care givers.

# Health IT and Certification in Support of APMs

## Workgroup Observations and Feedback



**Feedback**

- Explore and incorporate additional perspectives (i.e., patient/person, home health providers, etc.) as the workgroup envisions the success of these partners will be integral to providers' success. The current Ai analysis strongly reflects the provider perspective.
- Two additional functional domains from the provider perspective are:
  - The importance of bringing the output of data analytics (i.e., risk algorithms) into the operational care process workflow through well-designed decision support capabilities
  - Given the critical role of performance measurement in APM accountability, APM providers will be required to produce system level, provider level, and patient level feedback in order to successfully meet contractual targets. In particular, clinical quality metrics, utilization management metrics, and total cost of care metrics will require robust support.
- Given the conceptual importance of the care plan, the workgroup acknowledges the importance of promoting policies to advance the use and usability of care plans. The workgroup would build upon current thinking on the episodic care plan to meet the future APM needs of a person-centered longitudinal care plan.
- Prioritize integration of patient-generated (and patient device generated) health data
- Prioritize bi-directional engagement of patients

# DISCUSSION