Interoperability Experience Task Force

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Background

- Founded June 2014
- 8 MSSP ACOs in 11 states (3 in 2015, 5 in 2016)
- ~100k patients
- 115 Primary Care Practices
- ~30 EHR vendors
- 5 HIE endpoints for ADT
- ~ 1/3 of patients data extraction automated by May 2016

ACO Activity	Real-time ADT	CCDA/ Clinical	Claims/ Coding	Sched/ SIU
Managing High Risk Patients	X	X	-	X
Transitions of Care	X	-	-	-
Attribution and Risk		X	X	X
Referral Management	X	X	X	-
QM/QI	-	X	X	-

Top Challenges

Poor Ambulatory EHR Data Portability Compliance

Only **28%** of vendors provide ability to batch export C-CDA portability documents.

Only 68% provide capability to generate C-CDA automatically after visit

But, you can pay - $7,500 median cost of ownership for 3 provider practice. Range from $200 - $58k

Workflow -> Quality Measure Capture

Mapping burden is significant ~$4,000/practice above interface fees

Only 30% data completion rate for ACO quality reporting (2015 GPRO)

Inconsistent CCDA data availability:

- Imaging/surg procedure orders
- LOINC coded lab results
- Health maintenance
- Preventative screenings
- Counseling
- Referrals

HIE Coverage and Cost

2 out of 11 states have all hospitals connected

Challenges with business viability and data blocking by hospitals

Costs up to .12 pmpm,, pass through of vendor costs

~6 mos avg implementation cycle time

Reduced matching accuracy when patient panels not used (63% vs. 87%)

Missing code set standards (or compliance) (e.g. TIN directories, dispo codes)

Created neutral 3rd party organization to get coverage and governance issues solved in some markets

Solutions to Consider

Improved Inspection and Enforcement

Vendors exported 5 patients manually to pass data portability requirement

Improve CCDA data quality and completeness (we have gone to proprietary data formats)

Connect interop features and workflow required for data capture

Innovation Velocity

FHIR is interesting but a non-event for foreseeable future

Bidirectional interop - driving workflow and insight into the EHR, not just data extraction

Continue to develop code set standards and quality measure harmonization with exchange formats

Improve training and linking of workflow features to quality measurement

Address Data Blocking

Work to remove willful blocking practices e.g. health system "out of network" sharing

Provide neutral third party model where HIEs are weak or non-existent

Remove/reduce participation hurdles – authorization, duplicate fees