**Notes from Accountable Care Workgroup Call**

**Friday, July 19, 2013**

Attendees:

Workgroup Members:

* Charles Kennedy (co-chair)
* Grace Terrell (co-chair)
* Heather Jelonek
* Judy Rich
* Samuel VanNorman
* Joe Kimura
* Karen M. Bell
* Hal Baker
* Scott Gottlieb
* Shaun Alfreds

Ex-Officio

* John Pilotte

ONC Staff:

* Kelly Cronin
* Michelle Consolazio
* Alex Baker

**Recap of last meeting**

Charles Kennedy, Co-Chair, summarized key discussion points from the last meeting. Previously, the group discussed the importance of being able to link various HIT capabilities to value, noting this as the underlying premise of an ACO delivering population based healthcare that achieves the triple aim. The group discussed a framework released by the Certification Commission on Health Information Technology (CCHIT) which describes the functional requirements needed for accountable care arrangements. The group agreed to use this as a “jumping-off” point to guide a conversation about the technologies and capabilities that are needed to serve the needs of emerging accountable care arrangements. Dr. Kennedy described the key discussion questions guiding the call today:

* Are these the right functions for these areas? Are there any key gaps we can identify?
* What are the essential/baseline functions that you would prioritize for any accountable care arrangement?
* Where do you see major gaps in the market today around these essential functions?

### Discuss CCHIT Framework Element #1: Care Coordination

Grace Terrell, Co-chair, facilitated a discussion of the first area and presented framing statements to guide the discussion:

The Accountable Care Workgroup (ACWG) is concerned with advancing the evolution of a health IT infrastructure to support value-based payment models. A wide range of value-based payment models are currently being tested through both public and private efforts, including Accountable Care Organizations (ACOs), bundled payments, value-based purchasing, and advanced primary care payment initiatives. The ACWG seeks to identify a common set of core health IT capabilities that are broadly relevant across these arrangements, while recognizing that accountable care arrangements may vary in their specific health IT needs.

Members discussed each of the functions in the first area of the CCHIT framework:

* 1. **Access real-time health insurance coverage information.** Thiswas identified as an important function for care coordination. In Maine, it is driving the health information exchange to collect more coverage information to support transitions of care, offering the next provider access to the patient’s coverage and the ability to reconcile coverage with treatment options. However, while coverage information may be critical today, as patients increasingly move into closed and semi-closed networks, it may be less important in the future to understand different payer relationships and insurance schemes because patients won’t have as much discretion to go outside. On the other hand, benefit designs appear to be growing increasingly complex, i.e. varying degrees of benefits depending on which providers you see, suggesting that a richer transaction set may be required in order to be actionable by the provider, even as networks become more closed.

	Payers are now providing one ACO with a sort of ADT feed when patients are getting seen at hospitals and their eligibility is queried. This information is coming back on a daily basis and is proving very helpful to understanding where patients are accessing care.
	2. **Establish payer relationships.** Key capabilities is enabling a clinician making a referral toknow what coverage options are available in advance to reduce friction and blind ends that result from trying to match up coverage services with accepting providers, however, this would likely be a difficult task to take on.

	Members noted an emerging trend around new types of payer relationships, increasing the need to have clear delineation around who is providing which services to the patient around care coordination and ensuring services are delivered in a way that’s patient centric and highly coordinated. With a variety of payers and providers trying to engage in care coordination services like medication reconciliation. Currently, there is a real tension between whether care coordination is coming from the payer or the medical home provider, and potential for confusion for patients as to which care manager is supporting them and how they work with two different care managers supporting them for the same activity. It seems likely that one case manager working from the medical office will be more effective than 20 who are not communicating with each other. Functions 1.2 and 1.3 recognize that while different types of care management may be appropriately done in either the delivery system or payer setting for different purposes, an ACO or other contract arrangement will need to determine which entity provides which service, ensure communication between parties, and ensure services are provided in an effective manner.
	3. **Establish provider relationships.** This function seeks to capture all of the providers in the “medical neighborhood” around a given patient’s medical home, and drive toward lack of duplication and appropriate communication to support effective care coordination. Without having the established provider relationships and electronic messaging between them then there is no coordination of care, informed coordination of care using the data from each site. This is an important goal for NHIN Direct, which, if adopted, would offer a method of knowing who to communicate to and being able to do it very easily.

	It is also important to think more broadly about useful relationships with non-core providers where information can be captured and conveyed, for instance, when EMS providers visit a home but don’t end up picking anyone up, they still get a glimpse inside the home and can transmit information that might be useful to the primary care doctor.
	4. **Share data during transitions of care.** Going from this function to clinical information reconciliation (a later function under this heading) is tremendously difficult—a concern is that we can get into a situation where “data rich, but information poor.” Members discussed the possibility of natural language processing, an area where some vendors are developing “Google-like” functions that can get the core information using semantic ontology to get concepts. Cerner has a chart search function that is very effective when you have 10 years data.

Members agreed this is a very important step forward, and discussed the importance of exploring whether this area is mature enough to put forward a specific requirement yet, or whether it makes more sense to be guarded until solutions are more mature and proven. That question is dependent upon the standards by which we’re facilitating health information exchange between providers. Clinical information reconciliation is critical with concepts like continuity of care documents and the CDA architecture, whereas the answer will be different with discrete information exchange architecture like HL7.

Summarizing the group’s consensus, Grace Terrell noted widespread agreement that all of these functions are important, but integration in a way that doesn’t lead to information overload is an important distinction. Members discussed the degree to which current trends in the HIT application development market appeared to be advancing the maturity of these functions, noting that most of these functions would fall into the category of “maturing but not yet mature.” Interoperability continues to be the biggest obstacle to progress.

Policy solutions may be able to able to advance progress with respect to these functions. Firm statements that raise expectations of future government action by a given could accelerate progress. Recognizing elements such as semantic interoperability as an optional requirement or menu requirement could also help convey to the vendor community that these are critical steps to pursue.

Regarding interoperability, members noted that requirements need to be very granular. Vendors have looked at these policies and taken them as written instead of looking at interoperability as both the 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. Requirements could also be expressed in a way so that vendors need to do more than attest to the fact that they can accomplish a given task, and submit to compliance testing that demonstrates the technical ability to not only send and receive but make the data computable with other systems.

Members also commented that policy is most effective where it forces technology to happen where technology is the missing link to something that’s already the object of social and operational pressures that are driving user interest. Otherwise we run the risk of building something that nobody uses. Grace Terrell offered an analogy to the standardization of rail width for trains in the 19th century that was able to satisfy demand for seamless connections of rail networks.

Participants broadly agreed that remaining items were important to accountable care arrangements (1.5 Identify best setting for care; 1.6 Identify community and social supports; 1.7 Manage referrals; 1.8 Patient centric medication management and reconciliation; 1.9 Clinical information reconciliation)

**Discuss CCHIT Framework Element #2: Cohort Management**

Karen Bell facilitated a discussion of the second area discussed in the CCHIT Framework for Accountable Care, Cohort Management. Cohort Management really focuses on how clinicians take care of patients in an accountable care environment rather than a traditional model where the face-to-face encounter is the only moment of care. Cohort management is an assessment of the entire risk based population in orders to identity those specific cohorts on which the organization chooses to focus. In describing these functions, the CCHIT working group recognized that organizations are likely in multiple risk-based contracts, and that populations of focus often cover multiple payers. She then provided a provided a brief overview of all of the functions included.

* 1. **Identify desired cohorts of patients.** Members noted that cohort management has been much more effective when it is driven out of clinical data rather than administrative/billing data, both due to the chain of custody to where the provider is working as well as the difficulty encountered in using the finite number of codes used in billing to represent what a complex patient may have. While providers are constrained today by available data, we are likely to see increasing tension in favor of clinical data. Technology offerings to support this kind of data integration are not mature yet; the same lack of standards noted as a major barrier during the discussion on care coordination is a barrier to supporting the analytics necessary to do cohort and population management as well. Another challenge is that today we are mostly looking at either clinical or administrative data; in order to be truly population centric, we will need to see cohort identification algorithms run on integrated clinical administrative data. Finally, members discussed implementing common identifiers across multiple disparate systems—system level organizations are doing this now, but without the use of discrete data they won’t be able to do identification for population health.
	2. **Monitor individual patients.** Patient derived information in terms of their outcomes. Members discussed whether there is an opportunity to make recommendations on how to capture outcome data whether it is functional from some form of SF-36 or the other tools available.

	Members commented that there does not seem to be a lot of maturity in the marketplace for patient derived data yet, despite strong interest in the ACO marketplace to look at patient derived data as a critical outcome measure. For instance, clinical outcome measures for a prostatectomy don’t give you the same information as knowing a patient is satisfied at home. There seem to be a lot of options on the table for getting that patient derived data to date within the policies of Meaningful use. Cultural barriers among providers will continue to be a challenge for moving forward with patient derived data, leaving uncertainty about how quickly industry will move to embrace these functions. One interim step that might be considered is around home point of service labs and biometric monitoring equipment. These tools provide information through interactions with patients in a non-traditional setting, but they provide objective, measurable data rather than subjective data about patient experience.
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	4. **Clinical Decision Support** A lot of CDS exists in current systems and it is unclear whether there is much to add here.
	5. **Patient engagement.** The available data seems to show that decision support tools drive patients toward lower utilization of highly expensive or invasive procedures. For instance, patients are more likely to choose watchful waiting as opposed to dialysis or a prostatectomy if they make use of these educational tools. From a patient’s perspective, these tools seem to satisfy a very similar demand which is now being met by the internet. This seems like it should be highly appealing to ACOs—raising the question of whether there is a real need for external requirements or whether the market will provide sufficient support to develop these tools. Certification of the objectivity of these tools might be more useful than a certification that tries to address the presentation of information to the patient.

	Members discussed the importance of patient engagement to helping ACOs manage the leakage challenge. However, health systems may not know where leakage is occurring. When a member is trying to access care, need to engage patient at the moment when she is making a decision about where to access care. This is a key business model for health information exchange and an important service they can provide to ACOs, both in terms of providing data about when ACO-covered patients are leaking out of the system, but also through real-time alerts when patients show up at an unaffiliated emergency room or inpatient setting.
	6. **Engage preferred providers and clinicians.** Discussed previously.
	7. **Shared care management plan.** Members discussed the importance of advancing work around a standardized shared care management plan beyond today’s care summary record standard. Today patients are contending with multiple care plans that are not shared. Supporting development of this standard would be an important area for the Workgroup to explore. The Longitudinal Care Plan Workgroup under the Standards and Interoperability Framework has drafted an initial draft standard that they expect to ballot with HL7 over the next several months, which represents an important preliminary piece of work in this area. Significant work still needs to be done to think about a “wiki-like” care plan that could work in a variety of settings with a virtual care team.
	8. **Interventions.** Members noted this function seems to dovetail with patient engagement, where cohort management is contingent upon whether the patient is engaged and ready to do the things we’re recommending. We can look at 10 percent of the population from the delivery side and identify that they should complete a certain test, but outreach is challenging and results in a lot of churn and effort. What would be helpful is some sort of ability match interventions with engagement assessments.
	9. **Follow up.** A member noted a specific issue for concern around follow-up: tracking every basic test a provider orders in advance has the potential to be very complex when providers are co-managing a condition, given the amount of duplicate ordering that takes place. We need a way to understand that what the order intended to accomplish was accomplished, not to track each individual order, which is challenging to do across multiple EHRs.

**Next Steps**

The ACWG will revisit ideas gathered from this call in the future for potential policy recommendations.