**Health Information Technology (HIT) Policy Committee
Accountable Care Workgroup
Office of the National Coordinator for Health Information Technology

Charter
Updated: April 18, 2013**

**Broad Charge for the Workgroup:**

Make recommendations to the Health IT Policy Committee (HITPC) on how HHS policies and programs can advance the evolution of a health IT infrastructure that enables providers to improve care and population health while reducing costs in accountable care models.

**Specific Charge for the Workgroup:**

Within six months, make recommendations to the Health IT Policy Committee on how HHS policies and programs can advance the evolution of a health IT infrastructure that enables providers to improve care and population health while reducing costs in accountable care models.

**Rationale:**

The spread of successful, scalable models of accountable care will be contingent upon access to health IT infrastructure that seamlessly and efficiently facilitates stakeholder efforts to reduce the total cost of care for the populations they manage. While the HITPC’s work in areas such as electronic quality measurement and reporting, requirements for standards based exchange, and privacy and security policy is broadly aligned with accountable care imperatives, the HITPC has no dedicated resource to understand how emerging business priorities explicitly map to these initiatives. Given the proliferation of entities exploring accountable care models, rapidly emerging lessons about the factors critical to their success, and the importance of these models to national delivery system reform efforts, the HITPC would benefit from expert input on how policy recommendations can support and accelerate accountable care objectives.

**Background:**

Accountable care models must be able to aggregate clinical data across disparate groups of providers in order to carry core business functions, including:

* measuring and reporting on quality indicators;
* tying clinical data to payer data in order to track utilization;
* identifying at-risk patient populations that offer opportunities for improvement and savings; and
* ensuring patient data used within the organization is afforded appropriate privacy protections, and is available in deidentified form for secondary business and research purposes.

In addition, health IT infrastructure is a critical component of many of the interventions that will help accountable care models realize cost savings across the continuum of care, including:

* enabling the exchange of health information between primary care physicians, specialists, hospitals, FQHCs and critical access hospitals, health plans, patients, and other members of the care team to support care coordination;
* supporting widespread standardization of care around evidence-based guidelines;
* delivering business intelligence tools to providers; and
* supporting applications that engage patients in their care, allow patients to access their own health information, and increase patient capacity to self-manage chronic conditions.

A wide variety of stakeholders across the government, private industry, and the nonprofit sector have been working to understand how technology can enable successful execution of these functions. An existing workgroup on accountable care and technology comprised of representatives from ONC and the Center for Medicare and Medicaid Innovation (CMMI) has developed an extensive inventory of current initiatives looking at this intersection. Groups outside the government, including the Certification Commission on Health IT, the Dartmouth Collaborative, Premier, Avalere Health, the eHealth Initiative, and the Brookings Institution, among others, are all devoting substantial attention to this issue, and have begun to identify lessons from existing ACO-type models. The Accountable Care Workgroup’s task will be to translate this existing body of work into feasible, high-priority action steps for the HIT Policy Committee.

**Scope of Work:**

The workgroup will focus on specific high priority areas where programs and policies can shape the availability and use of health IT infrastructure necessary for accountable care models to realize the three-part aim. Likely areas of focus include:

* Supporting the evolution of data aggregation and analytics capabilities that are scalable and accessible across disparate providers for ACO success.
* Enabling and encouraging information exchange to support care coordination across providers, including non-core care and wellness providers that have a significant impact on readmissions rates and total cost of care for a patient, including long-term care facilities, home health providers, long term support services providers and other community-based organizations.
* Increasing patient activation as a member of a defined care team, engaging patients in assessments of their health, and using technology to deliver care to patients outside of traditional care settings.
* Aligning payment policy & health information exchange for sustainable ACO success.
* Improving the linkage between functionality and value creation.

The Accountable Care Workgroup will then make recommendations to the HIT Policy Committee about how ONC and other partners across HHS can use available programs and policy tools to accelerate progress in these areas.

* Uptake of Meaningful Use and certification of electronic health record systems (EHRs), for instance, recommending inclusion of quality measures critical to ACOs in certification guidance and considering certification of technology components for accountable care objectives;
* Standards and interoperability activities, for instance, providing input on work around developing standards for exchanging data with long term care facilities and incorporating data from remote monitoring devices used to manage chronic disease and prevent avoidable readmissions;
* Medicare Shared Saving Program guidance, for instance, provisions that would require or encourage Medicare ACOs to exchange health information as a part of their care coordination strategies; and
* Coordination opportunities across federal partners such as ONC, CMS, AHRQ, HRSA, and NLM, for instance, reconciling measure requirements between ACO and MU programs.

The meetings of this workgroup will be public and all documents discussed will be made available to the public.

**Workgroup Members:**

The workgroup emphasizes members with expertise in business aspects of accountable care models, which may include health system leaders, providers, and researchers. In addition, the workgroup will include representatives from federal partners.

**Chair**: Charles Kennedy, Aetna

**Workgroup Members:**

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| Shaun Alfreds | HealthInfoNet |
| Richard (Hal) Baker | Wellspan |
| Karen Bell | CCHIT |
| Karen Davis | Johns Hopkins Bloomberg School of Public Health  |
| John Fallon | BCBS Massachusetts |
| Heather Jelonek | John C. Lincoln Accountable Care Organization |
| David Kendrick | MyHealth Access Network |
| Joe Kimura | Atrius Health |
| Irene Koch | Brooklyn Health Information Exchange (BHIX) |
| Aaron McKethan | RxAnte, Inc. |
| Eun-Shim Nahm | University of Maryland School of Nursing |
| Judy Rich | Tucson Medical Center |
| Cary Sennett | IMPAQ International |
| Bill Spooner | Sharp HealthCare |
| Susan Stuard | THINC |
| Grace Terrell | Cornerstone Health Care, P.A. |
| Karen Van Wagner | North Texas Specialty Physicians |
| Samuel VanNorman | Park Nicollet Health Services |

**Ex-Officio Members**

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| Akaki Lekiachvili | CDC |
| Mai Pham | CMMI |
| John Pilotte | CMS |
| Westley Clark | SAMSHA |