

Consumer-Purchaser DISCLOSURE PROJECT

Better information. Better decisions. Better health.

April 22, 2013

Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: Interoperability RFI
Hubert H. Humphrey Building, Suite 729D, 200
Independence Ave, SW
Washington, DC 20201

RE: CMS—0038—NC Advancing Interoperability and Health Information Exchange (HIE) Request for Information.

Dear Dr. Farzad Monstashari:

Thank you for the opportunity to provide input on the Office of the National Coordinator (ONC) for Health Information Technology (HIT)'s and the Centers for Medicare and Medicaid Services (CMS)'s intent to accelerate interoperability and information exchange across the care spectrum. The Consumer-Purchaser Disclosure Project (CPDP) represents a collaboration of leading consumer, labor, and employer organizations committed to improving the quality and affordability of health care through the use of performance information to inform consumer choice, payment, and quality improvement. To truly transform the nation's health care delivery system into one that is person-centered and value-based, health information technology (HIT) must enable the interoperable exchange of high-value personal health data across settings of care and among patients and caregivers. Thus, we strongly support ONC and CMS exploring opportunities to encourage health information exchange beyond the Meaningful Use program.

A well-designed and implemented HIT infrastructure is essential to realizing the triple aim of better care, better population health, and lower costs. As a cornerstone for delivery system and payment reforms, HIT will enable new models of care to share data and integrate it across sources (including non-EHR) and types of data (i.e., clinical, claims, and patient-generated data). To realize the promise of HIT, *all* providers must adopt HIT that is capable of coordinating with other providers, measuring the quality of care, and giving patients and family caregivers the information they need to be active partners in health care.

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Our high-level recommendations for advancing interoperability and health information exchange are outlined below. Answers to the specific questions presented in the RFI are included in the Appendix along with additional information on Section II of the letter.

I. *Strengthening and Expanding Health Information Exchange Infrastructure*

The “Meaningful Use” of Electronic Health Records (EHR) Incentive Program is propelling a redesign of the health care system around patient- and family-centered health care—with HIT as its backbone—and serving as a catalyst for continued innovation. Among its accomplishments, Meaningful Use spurred the standardization of data elements and transmission methods, which are critical for uniform collection and sharing of health information. For example, the policymaking and parallel certification process has produced standardized data elements regarding critical records and processes of care, including:

- Summary of Care Record: The eligible hospital delivers a summary care record for 50% of transitions of care or referrals¹.
- After Visit Summary: Clinical summaries for patients following each office visit.
- View, Download, Transmit (V/D/T): Provides patients the ability to view online, download and transmit their health information, and specifies the types of information that must be made available.

We believe the advances made through Meaningful Use, like those above, should be extended broadly across *all* providers, not just those that are Meaningful Use eligible. And we need more robust information standards than what is in the Meaningful Use program to fully realize the potential of information exchange. We urge HHS to extend the Meaningful Use program’s impact by advancing requirements that create standardization for a range of data and functions. In particular, HHS should advance the method used to transport data elements between systems. The process should be simple, secure, scalable, and standards-based. Although the Consolidated CDA standard for the electronic transfer of a Care Summary and the Direct standard² provide a framework, the task of enabling EHR systems to incorporate standardized data elements directly into the medical record is not complete. Something as straightforward as improving emailing capabilities would go a long way towards improving communication.

¹ By way of example of the uphill battle this poses, a study conducted in 2009 found that 73% of the time, primary care providers in the United States did not receive discharge information from hospitals within two days of their patients’ discharge. Furthermore, the discharge summaries that were sent to the primary care providers were seldom transmitted electronically. Commonwealth Fund. 2009. Commonwealth Fund international health policy survey. New York (NY): Commonwealth Fund; 2009. Available at: <http://content.healthaffairs.org/content/31/3/527.full.pdf>.

² Available at: <http://wiki.directproject.org/file/view/DirectProjectOverview.pdf>.

II. Using Measurement to Encourage Health Information Exchange

The health system often fails to adequately coordinate care across a fragmented system of providers. With half of Medicare beneficiaries being treated for five-or-more conditions³ and chronically ill patients seeing a median of seven different physicians per year⁴, the benefit of improved care coordination is obvious. Measuring and rewarding activities that are enabled by information exchange—such as care coordination—will drive the adoption and use of HIT. HHS should implement a limited set of high-value measures that leverage functionalities, which support new payment and delivery models, only possible in an electronic environment. The measure set should be parsimonious and integrated across federal programs. HHS should also support the widespread alignment of measures by incenting states and collaborating with private payers to use these measures.

Although using already existing measures is a good way to start, there are significant measurement gaps in areas that encourage health information exchange. Thus, new measure development is necessary to the successful use of measures in promoting health information exchange. HHS must allocate some of its current measure development funds and resources to filling these gaps. These resources must go to the development of high-value measures, while low-value measures become obsolete. For more information on designing measures, please refer to [Ten Criteria for Meaningful and Usable Measures of Performance](#).

Health IT and health information exchange elevate the capacity of measures to assess the quality of care in general (i.e., not just for activities enabled by information exchange) by making data collection and distribution more agile. For example, using HIT to collect data across time (longitudinal measurement) and space (the spectrum of providers) creates a more complete picture of patient outcomes than the pinhole picture derived from a singular event. Patient reported outcomes (PROs) can also increase the capacity for data collection and use in care management and, when reflected back to patients, supports shared decision-making between providers and patients. In the Appendix, we provide additional detail on measures of care coordination (including how patients themselves can provide an indication of how well coordination is occurring) and PROs that can be included in the measure set.

Registries that capitalize on HIT are a viable source of data for current and new measures that assess activities that encourage health information exchange. Electronic clinical registries are typically used by clinicians to manage patients with chronic conditions or, in surgical specialties, to benchmark performance against their peers. For registries to take advantage of health information exchange,

³ Peikes, Deborah, et. al., *Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries*, JAMA. 2009;301(6):603-618. doi:10.1001/jama.2009.126.

⁴ Pham HH, Schrag D, O'Malley AS, Wu B, Bach PB. *Care patterns in Medicare and their implications for pay for performance*. N Engl J Med. 2007;356(11):1130-1139.

however, they need to meet certain criteria. For example, registries should electronically interface with other data sources, including both EHRs and other sources of data that might not be included in the EHR (e.g., imaging, product bar code, other settings). For instance, a surgeon's private practice EHR may not be integrated with the EHR at the hospital where she practices, but both the surgeon's and hospital's EHRs can supply data to the registry. They should also be able to transmit data electronically to third parties (e.g., vendors, CMS). Additionally, registries should use standards for common data elements, such as LOINC codes for laboratory data and NCPDP standards for pharmacy data. A critical element to sharing registry data via health information exchange is for HHS to develop data and interoperability standards and find ways to encourage EHR vendors to adopt those standards.

Finally, there are specific functionalities that can only be leveraged in an electronic environment that support HIT-enabled measures. HHS should add these functionalities to HHS program requirements to improve the availability of high-value measures. These include:

- Capturing patient information such as patient identifiers, contact information, caregiver information, and primary language;
- Encouraging the transmittal of data between providers, such as offering provider directories mapped to Direct addresses and standard identifiers;
- Ability for patients to contribute information to their medical records that is related to their care; and
- Ability to interface to claims/administrative data using common identifiers (e.g. plan member ID) to permit construction of longitudinal measures.

III. *Spreading HIE Through Incentives and Requirements*

We strongly support using a variety of incentives and requirements to create a functional HIT *system* for managing and improving health care, rather than a constellation of separate HIT programs working in parallel but not in concert with each other. Ensuring that providers maximize the use of HIT to improve quality and efficiency is central to transforming the health care system. Extending Meaningful Use requirements to other providers and going beyond these requirements are important to accomplishing this. To do so, HHS should use a variety of incentives and requirements to spread more effective HIE.

The Innovation Center is testing new models that promise to advance strong infrastructure and processes for health information exchange, which are fundamental to achieving the improved quality, care coordination, patient-centeredness, and cost reduction goals of the following programs:

- Accountable Care Organizations (ACOs);

- Comprehensive Primary Care Initiative;
- Bundled Payment for Care Improvement Initiative;
- Independent At Home Demonstration;
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration;
- Medicaid Health Homes; and
- Community-Based Care Transition Program.

Applicants to the Innovation Center—for demonstration and pilot projects—should describe how they use interoperable technology to advance health information exchange in care coordination, quality improvement, and patient and family engagement. The Innovation Center should also evaluate whether the demonstrations and pilots include measures of providers' performance that are indicative of whether or not care was coordinated and information was exchanged electronically. Additionally, CMS should incorporate these measures into other Medicare programs not run by the Innovation Center, such as the Inpatient Quality Reporting, Hospital Value-based Purchasing, Physician Quality Reporting System, and Physician Value-based Modifier.

HHS should also work with states to spread the use of health information exchange. HIE adoption is hampered by state-level variation in programs and policies, making it challenging for multi-state care organizations and vendors to create scalable processes and products. Where there are federal components to state programs, HHS can use its authority to encourage HIE. Some examples include:

- When CMS approves state waivers for advanced payment models, it should require alignment with the core set of high-value HIE sensitive measures mentioned above for Medicare programs.
- CMS should include HIE requirements in state advanced payment models and other programs.
- HHS should work with states to implement common language across state employee health plans and Medicaid that will help advance HIE. For instance, states could require in solicitations (e.g., Medicaid managed care organizations, state employee health plan) that applicants require participating providers to electronically exchange health information at care transitions.

In closing, engineering a HIT infrastructure that draws data from across the care spectrum, encourages information exchange, and cultivates a stable of high-value measures will significantly increase the yield of HIT and move the nation's health care delivery system into one that is person-centered and value-based.

Sincerely,



Debra L. Ness
President
National Partnership for Women & Families
Co-Chair, Consumer-Purchaser Disclosure Project



William E. Kramer
Executive Director for National Health Policy
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APPENDIX: Questions for Public Comment

#2: Which programs are having the greatest impact on encouraging electronic HIE?

The Meaningful Use program, and the standards deployed through the HHS Certification program, lay the groundwork for encouraging electronic HIE. We believe the advances made through Meaningful Use, like those cited in the body of our letter, should be extended broadly across all providers, not just those that are Meaningful Use eligible. We also recognize the need for more robust information standards than what is in the Meaningful Use program to fully realize the potential of information exchange. We urge HHS to extend the Meaningful Use program's impact by advancing requirements that create standardization in the marketplace for a range of data and functions, such as the method used to transport data elements.

#3: How do current CMS payment policies encourage or impede electronic HIE across health care provider organizations, particularly those that may be market competitors? What CMS and ONC programs and policies would address disincentives for HIE that result in "Data Lock-in"?

At the most fundamental level, the fee-for-service payment model impedes electronic information exchange by paying providers for their volume of services regardless of quality of care provided. While we believe CMS must move towards more sophisticated risk-based payment models, we recognize transitioning away from fee-for-service is not a short-term endeavor.

The Meaningful Use program provides incentive payments to encourage and support the implementation of electronic health records and is laying groundwork for health information exchange. Other HHS payment policies, such as accountable care organizations (ACOs), bundled payments, and other value-based purchasing models provide some minimal incentives to electronically exchange health information, if any at all. This is a ripe area for using incentives to encourage electronic HIE.

In terms of data lock-in, the functionality of View/Download/Transmit (V/D/T) allows consumers to direct the sharing of their information across providers, even market competitors. Giving consumers the power to V/D/T their own health data ensures that patients and families—and their health information—are not tethered to any one provider, portal, or personal health record, and can be aggregated across multiple providers and settings of care. As such, HHS should widely encourage Blue Button and other opportunities for consumers to electronically access and direct their personal health information.

#8: How can new authorities under the Affordable Care Act for CMS test, evaluate, and scale innovative payment and service delivery models best accelerate standards-based electronic HIE across treating providers?

All new Innovation Center demonstration and pilot applicants should be required to demonstrate—in advance—how they are using interoperable technology to advance HIE in care coordination and quality improvement. Evaluation of the demonstrations and pilots should also include providers' performance on quality measures that are indicative of whether or not care was coordinated and information was exchanged electronically. See the section below on care coordination and patient-reported outcomes measures for specific suggestions. Additionally, most new delivery models require care assessment and/or care planning. Care plans should be available electronically so patients can update and share relevant information with other members of their care team.

We recommend the following specific initiatives to foster information exchange in ACOs and bundled payment. Many of the recommendations also can apply to other programs (e.g., Comprehensive Primary Care Initiative, Community-Based Care Transitions Program).

Accountable Care Organizations

There are some basic requirements in place for ACOs regarding electronic medical records. Pioneer ACOs must attest that at least 50 percent of the ACO's primary care providers have met requirements for Stage 1 Meaningful Use, and both Shared Savings ACOs and Pioneer ACOs are required to report on a quality measure that assesses the percent of participating primary care providers who successfully qualify for an EHR incentive payment. Given the success of the Meaningful Use program, however—and the role that ACOs should be playing as leaders in coordinating care—ACOs should be held to a higher standard and must lead the way in fostering health information exchange. We recommend:

- Quality measures that indicate whether or not care management includes health information exchange should apply to hospitals and any Eligible Provider under Meaningful Use who is part of the ACO arrangement.
- ACOs should be accountable for whether patients and families say their providers are coordinating care. This could be accomplished via a patient experience survey question that asks about the extent to which a patient's provider is informed about the care the patient received from specialists or other providers.
- ACOs should be held to higher requirements for sharing care summaries electronically than is currently required in the Meaningful Use program. ACOs should facilitate the provision of

electronic communication infrastructure, such as by making the Direct standards and services available to all their participating providers. ACO participants should use the Direct standard, or a compatible service or capability, to transmit Summary of Care records and, eventually, care plans. Stage 2 of Meaningful Use will require a Summary of Care record to be provided for 50 percent of transitions and referrals, and to provide the record electronically for more than 10 percent of transitions and referrals. Stage 2 will facilitate more robust health information exchange, and ACOs should lead the way.

- ACOs should have standards and processes in place for beneficiaries to electronically access their health information in a way that is aligned with the “View/Download/Transmit” criteria in Stage 2 Meaningful Use (at least among providers that are eligible for Meaningful Use). This would enable consumers to share their health information with every member of their care team.

Bundled Payment Initiative

In selecting entities to participate in the bundled payment initiative, CMS indicated it would give preference to those who are Meaningful Users or who have a minimum of 50 percent of providers meeting the standards for Meaningful Use (including the ability to electronically exchange patient Summary of Care records with relevant providers as necessary to ensure care coordination, medication reconciliation, and prevention of readmissions).

- We strongly support giving preference to applicants who are Meaningful Users, but urge rapid advancement toward Stage 2 Meaningful Use.
- Applicants should also facilitate the provision of electronic communication infrastructure, such as by making the Direct standards and services available to all their participating providers or using a comparable service to transmit care plans and summaries. (Please refer to comments regarding ACOs for further detail).
- Applicants should also have standards and processes in place for beneficiaries to electronically access their health information in a way that is aligned with the “View/Download/Transmit” criteria in Stage 2 Meaningful Use (at least among providers that are eligible for the Meaningful Use program).

Using Measurement to Encourage Health Information Exchange

The interoperable exchange of personal health data across providers and between providers and patients will help facilitate a more effective and efficient health care system. A supplemental benefit is using the data to support other activities, such as performance measurement. Below, we describe two areas of measurement—care coordination and patient reported outcomes measures—that are activities enabled by information exchange.

Care Coordination

There are two consistent complaint areas for patients interacting with the health care sector: lack of communication and lack of coordination⁵. The idea behind *care coordination* is simple: the care patients receive should be coordinated between each of their health care providers and across the settings where they receive care. Health information exchange is an important vehicle for improving care coordination, and the overall effectiveness and efficiency of care provided to the patient.

While the idea behind care coordination is simple, it is a multifaceted concept that does not have a universally adopted framework. Thus, the first step towards addressing the development of care coordination measures is producing a framework and identifying priority measure concepts. HHS should fund this; we recommend building off of previous work from the Office of the National Coordinator (ONC)⁶, AHRQ⁷, and others.

An important element to assessing care coordination is the patient's experience; patients can provide valuable insight on whether or not care was coordinated. A recent study showed 45% of patients reported having to act as communicator between doctors who are not talking to each other⁸. There are currently available patient experience surveys that assess aspects of care coordination. For example, the Patient-Centered Medical Homes Consumer Assessment of Healthcare Providers and Systems (PCMH CAHPS) survey focuses on: access, information, communication, coordination of care, comprehensiveness, self-management support and shared decision making. Questions that address care

⁵ Lake Research Partners for the National Partnership for Women & Families, 2010. Available at http://www.nationalpartnership.org/site/DocServer/Lake_Poll_Media_Report_FINAL.pdf?docID=6242. This study found that 45% of patients reported having to act as communicator between doctors who are not talking to each other.

⁶ In 2010, the Office of the National Coordinator (ONC), with the help of external experts, identified a list of critical areas for measure development, including care coordination and quality of shared decision-making.

⁷ AHRQ's *Care Coordination Measures Atlas* is a framework for care coordination measurement, documenting and mapping over-60 existing measures to key care coordination activities and different perspectives of key stakeholders. Available at <http://www.ahrq.gov/professionals/systems/long-term-care/resources/coordination/atlas/index.html>.

⁸ Lake Research Partners for the National Partnership for Women & Families, 2010. http://www.nationalpartnership.org/site/DocServer/Lake_Poll_Media_Report_FINAL.pdf?docID=6242.

coordination include care from other providers and care from others on the care team. It is used by NCQA in its PCMH Recognition Program and can also be used by practices for internal quality improvement.

The CAHPS products also include a supplemental HIT Item Set⁹ focusing on patients' experiences with the use of HIT in physicians' offices. It contains 21 items across three content areas: provider use of computer or handheld devices, email access and helpfulness, and helpfulness of HIT. It was developed with an eye towards which HIT functions were important to patients, patients' views of HIT's role facilitating those functions, and how patients viewed the roles for HIT in a physician practice. Although this survey looks at whether patients have *access* to online personal health information (i.e. laboratory or other test results, listing of their prescription medicines, physician's notes from prior office visits), the survey must evolve to ask about patients' experience with these functions and how valuable they find them; this additional testing work can be supported by HHS.

Another example of a patient-centered measure is the NQF-endorsed Care Transitions Measure (CTM-3)¹⁰. Administered at the time of hospital discharge, this three-question survey measures three areas that patients identified as critically important to their experience with coordination out of the hospital: self-care in the post-hospital setting, medication management, and adherence to patient preferences in the care plan. In contrast to other measures that focus on hospital discharge, the CTM-3 inspects *whether* and *how* hospital staff prepared the patient for discharge and includes reference to family caregivers, an important partner in care coordination. Notably, the CTM-3 has been found to predict re-hospitalization and return to the emergency department, underscoring the fact that care coordination is essential for both patient outcomes and cost containment.

Patient Reported Outcomes Measures

Patient-reported outcomes measures include information collected from patients to elucidate on aspects of their care in which they are the expert (e.g., pain management, activities of daily living, functional status). This information supports a collaborative care management model and shared decision-making when results are shared with both patient and provider. There are two basic models for how information is entered by the patient, which are not necessarily mutually exclusive: (1) the patient is invited via e-mail to enter data from his/her home computer through the provider's patient portal,

⁹ Available at http://www.cahps.ahrq.gov/clinician_group/cgsurvey/aboutthehealthinformationtechnologyitemset.pdf.

¹⁰ Available at <http://www.caretransitions.org/documents/CTM-3.pdf>.

and (2) the patient is asked to enter data at point of care using a provider-owned tablet or kiosk computer. Additional models may develop, including those that utilize personal health records (PHRs).

Some examples of EHR-enabled quality measures that use data directly entered by patients are as follows.

- The Dartmouth Institute (TDI) is tracking PROMs over time to determine the impact of treatments on outcomes and the experience with care. The PROMs they are tracking include four clinical populations: (1) annual wellness visit, (2) heart failure, (3) hip replacement, and (4) knee replacement.¹¹ They believe PROMs will improve patient engagement and the quality of patients' decisions about health and health care. To promote widespread use of PROMs, TDI has made available a data collection platform and benchmarking capability, and facilitated training and sharing of best practices.
- Partners Healthcare is in the second phase of a two-phase PROMs pilot for CABG procedures and diabetes care. During the pilot, they are collecting PRO data through a multi-modal approach¹², reporting PRO measures to providers and patients, and using PRO data as quality metrics on a physician, clinic, hospital, and system level.¹³
- Consultants at Royal Cornwall used PRO measures data to monitor via a website post-surgical patient health following hip and knee replacements. The intent of the initiative was to improve patient health, encourage better compliance with post-surgical therapy, and reduce the need for face-to-face post-op outpatient appointments. This model of having patients report health outcomes via website could be adopted by other providers to collect information in a streamlined way that is straightforward and accessible to most patients.

#9: What CMS and ONC Policies and Programs Would Most Impact Patient Access and Use of Their Electronic Health Information in the Management of Their Care and Health?

Health IT systems must enable providers to safely and securely share information, not just with each other but with patients and families. Consumers can be true partners in health and health care only if they have access to the comprehensive and accurate information they need to be engaged in care.

¹¹ For details on the condition specific and general health measures being used, see The Dartmouth Institute's Survey Administration Tool (SAT): <http://tdiprm.dartmouth.edu/overview.php>.

¹² Modes include interactive voice response (IVR) combined with human phone operators, electronic tablets in the health care facility, and an internet patient portal.

¹³ For more on this pilot, see *Patient Reported Outcomes: Measuring Patient-Centered Healthcare Value Across the Continuum of Care at Partners Healthcare System*, Eyal Zimlichman MD, MSc, 22 October 2012. <http://www.isqua.org/docs/geneva-presentations/a5-eyal-zimlichman.pdf?sfvrsn=2>.

Giving patients the ability to view, download, and transmit (VDT) their own health information was a monumental advancement for consumers in Stage 2 of the Meaningful Use program. HHS should expand the use of innovative tools like the Blue Button that allow patients and families to access and use their health information as they see fit.

As the HIT Policy Committee explores alternative approaches for demonstrating Meaningful Use in Stage 3, particularly the idea of deeming based on performance (under consideration by the Deeming Subgroup of the Meaningful Use Workgroup), it is critical that the VDT functionality is maintained as a separate use requirement until more robust data on patient use is available. In other words, the VDT requirement should never be “deemed” completed by a providers’ performance on another related requirement.

Additionally, we strongly encourage HHS to plan and implement corresponding beneficiary engagement and education efforts that will be a necessary to fully realize the potential of patient access and use of their electronic health information. For example, current Medicare beneficiaries who download their claims data from CMS via Blue Button may easily be overwhelmed by the amount, complexity, and clinical nature of the information they receive. It is incumbent upon HHS to ensure that consumers are aware of tools like the iBlueButton and other applications that upload, organize, and display this information in ways that are understandable and useful to patients, families, and providers. At a minimum, CMS should prominently display information explaining the availability of these applications and other resources on the MyMedicare.gov website, preferably next to the Blue Button. CMS should also encourage beneficiaries to electronically access and download their health information (and explain how to do so) as part of the Medicare Annual Wellness Visit. Ensuring that beneficiaries have the information they need to manage their health and health care is a critical component of efforts to develop or update a personalized prevention plan.

#10: What specific HHS policy changes would significantly increase standards-based electronic exchange of laboratory results?

In Stage 3 of Meaningful Use, CMS should make the Eligible Hospital objective to provide structured electronic lab results to ambulatory providers a core measure and increase the threshold providers are required to meet as aggressively as possible, as the HIT Policy Committee proposed in the Stage 3 Request for Comment (RFC). For example: requiring hospitals to provide 50% of lab results electronically to ambulatory providers. Additionally, CMS should require as condition of payment for laboratory providers the transmittal of lab results to CMS or a designated 3rd party vendor.