Denise Myshko

ACA A Data *Sharing* Imperative

The sharing of data has become a critical success factor in the healthcare market under the Affordable Care Act.

The Affordable Care Act changes how healthcare data need to be collected, managed, and analyzed. Accountable care organizations, providers, and payers will require connections between complex information systems and analysis of large volumes of data. It will only be through sharing of data, experts say, that healthcare stakeholders — including payers, providers, and biopharma companies — will truly be able to accurately measure quality and understand outcomes of various treatments and therapies. Patient data will be captured in electronic health records and provider reimbursement will be tied to quality measures.

Health IT is the lynchpin to being able to achieve any kind of outcomes within the Affordable Care Act, says Lynn O'Connor Vos, president of ghg.

"Health systems need to connect all of the constituents of healthcare so that we can improve care coordination and how people are using the system, as well as address the cost to the system," she says. "We need a specific call to action that will unite all key stakeholders to the mission of delivering high performance healthcare, one that will cut back overutilization, coordinate care and lead to better communications."

The Affordable Care Act has put an imperative around sharing and exchanging data between players in the healthcare ecosystem that need to work together on the patient care pathways, says Todd Skrinar, principal, life-sciences advisory practice, EY.

"There is a need now to work together in ways they haven't had previously," he says.

There is now more clinical data available because of the widespread adoption of electronic health records, says Bill Fera, M.D., principal, healthcare advisory practice, EY.

"For the first time, we are able to start marrying clinical data and financial data to define value around outcomes, thereby creating best practices," he says. "This is being driven by the Affordable Care Act."

The most visible piece of the Affordable Care Act as it relates to data is in the way Medicare is going to pay providers, says Jordan Battani, managing director, Global Institute for Emerging Healthcare Practices, at CSC.

"Medicare has traditionally paid providers on a fee-for-service basis so physicians and hospitals have traditionally focused on maximizing rates," she says. "The Affordable Care Act has many interesting experimental ways of paying providers that are designed to change the metric from volume of services to outcomes and results. There are various incentive payments that are associated with achieving quality outcomes and metrics in different populations. There are also initiatives for failing to meet quality standards. One of the high profile penalties is the preventable hospital readmission penalty."

These new innovations require hospitals and providers to keep track of services provided and they now also have to integrate the actual clinical results, Ms. Battani says.

"The information that needs to be captured is getting much broader because it has to include clinical and outcomes information, and the time span over which that information has to be collected is expanding," she says. "Providers have to figure out ways of tracking the patient's progress after discharge because that also ties into how reimbursement will happen."

In addition, Ms. Battani says, providers now have to provide this information not just on a discreet patient level, but for populations as well.

Dr. Fera says this effort will be more successful than managed care's previous attempts to develop best practices.

Information Exchanges: The Challenge to Connect

1. Achieving interoperability with disparate information systems is a major concern; 68 initiatives in a recent survey have had to connect to more than 10 different systems.
2. To overcome interoperability challenges, exchanges would like to see standardized pricing and integration solutions from vendors.
3. Many exchanges are not sharing data with competing organizations.
4. Exchanges are focusing on functionalities to support health reform and advance analytics.
5. Patient engagement remains low among organizations exchanging data.
6. Patient consent for data exchange generally remains an all-or-nothing proposition.
7. In the last two years, more data exchange initiatives have become financially viable. But hospitals and payers are still expected to fund most exchange activity.

Source: eHealth Initiative

"The governance of these new reimbursement methodologies is being shared with accountable care organizations so there is now an opportunity to integrate clinical data," he says. "We have the ability to track providers who are providing good care and driving outcomes — not just managing to process measures or costs. For example, for care of diabetics, we can start to see not only if physicians are ordering hemoglobin A1C's but if those hemoglobin A1C's are under control, thereby identifying physicians with the best outcomes."

Ms. Battani points out that although these requirements fall to the public sector to provide, the private sector is creating quality-based payment innovations as fast, or faster, than the public sector.

"The role of the government both at the state and federal level in promoting effective information exchange has been very large," she says. "There were a number of big initiatives to create public health information exchanges that were heavily subsidized by federal and state money. Those have been more successful in some places and not successful at all in other places. There's now considerable private sector innovation in health information exchange, and going forward we'll see a mix of public and private enterprises engaging in these efforts. There is a lot of innovation happening as organizations and vendors try to figure out plug-and-play solutions."

At first there was a hesitancy among provider organizations to make large capital expenditures for fear of being wrong, says Jay Dunlap, general manager at EXL Landa.

"In the 2009 to 2011 timeframe, we saw IT tactical level planning but not larger, strategic level planning because there was uncertainty about the future," he says. "Now that early elements of the ACA have been applied there is a rush of expenditure dollars that aim to make sure IT is compliant and strategic in nature."

Mr. Dunlap says in the last five years, there has been more honest discussion of data integration.

"We see people much more open to collaborative care and looking at patient outcomes, population outcomes, and the spending in these areas," he says.

The Need for Data Sharing

Federal funding and health information technology incentives are a big part of this information technology movement. By the end of January 2013, The Centers for Medicare & Medicaid had distributed more than half of the total funds that were expected to be paid out as incentives for EHR implementation under the American Recovery and Reinvestment Act of 2009. These payments began in 2011 and are expected to eventually total $22.5 billion.

More than 40% of practitioners are using EHRs, an increase from 12% in 2009, according to EY.

Tom Browning, director of corporate compliance and security at Telerx, says the private sector is taking a major role in providing quality healthcare systems for patients, healthcare providers, and networks, and at the same time they are providing cost measures for all parties involved.

"The private sector has the technology and business processes to do this," he says. "For example, we could potentially coordinate a program with a pharma company that could provide samples of drugs to patients who otherwise couldn't afford those drugs. We coordinate the ordering and the distribution of those drugs from the healthcare provider to the pharmacy and then back to the patient."

Mr. Browning, however, stresses that data integration efforts have to safeguard patient data.

"Our focus is to maintain the integrity of that patient data and not have it compromised

> "There is a great opportunity for revenue generation with regard to healthcare programs, but the bottom line is the protection of that personal healthcare information."
>
> **TOM BROWNING** / Telerx

> "We see companies evaluating new ways of analyzing data that lead to value, and they are looking at ways to do this, such as with a third party or through partnerships or completely outsourced services."
>
> **DR. BILL FERA** / EY

in any way," he says. "With each new program that we evaluate, we develop specific processes to protect patient data."

Mr. Browning says cloud technologies are now beginning to address privacy in the healthcare arena.

Sharing patient data outside a healthcare system remains a significant obstacle, according to eHealth Initiative's 10th annual survey of health information exchanges (HIEs) that was released in November 2013.

The use of electronic health records and other electronic information systems have made data sharing within hospitals and health networks routine. But there is now a need to integrate that data with clinical and administrative systems outside of existing networks. Three-quarters of the participants surveyed by eHealth Initiative report that they have had to construct numerous interfaces between different systems to facilitate information sharing, a process that is both time consuming and expensive. In fact, of those surveyed, 68 organizations have had to build 10 or more interfaces with different systems.

In healthcare, interoperability is the ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged, according to the Healthcare Information and Management Systems Society (HIMSS). Interoperability means the ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities.

Dr. Fera says organizations are only just beginning to put in place systems for data integration.

"Right now, organizations are implementing application level analytics, where they take information from a specific application such as electronic medical records and analyze that data," he says. "While we can get helpful information from this approach, that analysis is limited to that application. When we start to marry that clinical information with financial or claims information, that's where we can aggregate the data to create an enterprise view. We can also start to introduce more advanced capabilities around machine learning and prescriptive analytics."

Dr. Fera says commercial payers are putting the infrastructure in place to create interoperable platforms so they can have ability to start harnessing the data for advanced analytics. But he points out that there is still much to be done, especially in the area of technical issues, data standardizations, obstacles related to ownership of data, and issues related to patient privacy.

Mr. Skrinar says analytics with maturing capabilities, combined with open architecture and cloud computing, are helping more organizations of all sizes and levels of resources better manage data and be able to make decisions on that data. He says there is an opportunity for data-centric service providers to help enable those partners. That isn't happening very frequently right now.

"A data-centric service provider would create a service for an unmet need that is either based on the provision of scarce data or analytics on data that already existed or both, such as predictive analysis for payers based on integrating health profile data with claims data," he says.

Mr. Dunlap says payers need to first integrate system internally to use the data they already have but today are in siloed systems.

"Most of my clients have between two and five legacy claims systems with different data formats and don't exchange data," he says. "But they have enormous IT staff and budgets trying to get these systems live and interoperable. There is a wall between population health management and data and analytics. Every one of my clients has an enterprise data warehouse and they have large teams of actuarial trained staff and database administrators but they are very rarely brought together in a way to act upon that information.

Mr. Dunlap says companies need a comprehensive strategy for data integration that addresses organizational silos.

"There might be a level of fiefdom mentality or a too narrow view of the data that individuals control and access," he says. "There needs to be a CFO/COO for the operations and a CMO of the organization meeting together to create and enact strategies that accelerate the use of existing data.

"There are projects that are six months to 12 months in length that could be enacted in 2014 that would bring material changes to health outcomes and decreased clinical risk and increased member engagement," Mr. Dunlap continues. "With the right leadership at the organization and the right support from external payers that have those capabilities companies can make dramatic changes in magnitude of orders of change. These are not the most expensive projects. EMR installations or claims systems consolidations are occurring and those are very large, valuable projects. What I am speaking of is taking existing data and looking at them intelligently with a clinical and financial mindset and then creating actionable workflow that can support clinical decision making."

Pharmaceutical companies, Mr. Skrinar says, will need to partner with payer and provider organizations in this integration.

"The learnings from data integration will help pharma provide better outcomes and assess their therapies with alternate therapies," he says. "R&D organizations will be able to do research and create new helpful therapies more quickly with fewer resources. For both of those objectives, combining the real-world data with genomic data that are used in the research process, creates an opportunity to help pharma companies fail faster and create an opportunity for them to have very targeted analysis of how a therapy is going to work for a very specific set of patients relative to the other alternatives that are available."

"I envision virtuous circles created by networks of payers, producers, and in some cases clinical research organizations and providers that bring the data sources together to advance the benefits of all parties," Mr. Skrinar says. PV