American Hospital Association®

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

June 1, 2016

Karen DeSalvo, M.D.
Acting Assistant Secretary for Health
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Suite 729-D
Washington, DC 20201

Re: Request for Information Regarding Assessing Interoperability for MACRA *(HHS-ONC-2016-0008)*

Dear Dr. DeSalvo:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to respond to the request for information (RFI) on how best to assess progress on achieving interoperability and sharing of health information that the Office of the National Coordinator for Health Information Technology (ONC) included in the April 8 *Federal Register*.

In the RFI, ONC asks for feedback on the scope of measurement for interoperability, as well as data sources and potential metrics. The agency plans to use the input it receives to guide implementation of a requirement in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 that ONC establish metrics to determine whether the nation has met the objective of widespread interoperability.

The AHA concurs that interoperability is a national objective and supports your efforts to measure progress. We also strongly support the creation of an efficient and effective infrastructure for health information exchange that facilitates the delivery of high-quality, patient-centered care across health care settings. Hospitals and health systems view information exchange as vital to care improvement, as well as to successful implementation of new care delivery models. Our comments on the scope of measurement and possible data sources follow.

SCOPE OF MEASUREMENT

The AHA recommends that ONC expand its scope of measurement beyond just the exchange and use of electronic health information to include whether we have the standards, technology and infrastructure needed to support these goals. We also suggest refinements to the approach for measurement.

The MACRA defines interoperability as the "exchange of clinical and other information and use of the information that has been exchanged using common data standards to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improve patient outcomes." In the RFI, ONC proposes to measure "exchange" and "use" of electronic health information. It does not, however, seek input on how to assess whether we have the correct infrastructure to support exchange.

The AHA recommends that ONC consider developing measures about the extent to which we have the standards, technology and infrastructure in place to facilitate exchange. Without those building blocks in place, providers are challenged to efficiently and effectively exchange and use health information. Data have shown that we do not currently have a sufficiently robust infrastructure to support exchange. For example, in the 2015 Health IT Supplement to the AHA Annual Survey, 51 percent of more than 3,500 respondents (unweighted data) indicated that they face challenges exchanging data across different platforms, suggesting lack of standardized approaches. In addition, 52 percent (unweighted data) reported that they have difficulty locating the address of a desired recipient, due to the lack of widely available provider directories. These are just two of the infrastructure items that must be in place for providers to effectively exchange and use electronic health information. Another missing infrastructure item is a unique patient identifier or other national solution that allows providers to know with confidence that shared information is about the same individual. The AHA also has commented previously on the need for ONC to not only name standards, but assess their readiness for use by providers and educate providers on how they are used in practice (Nov. 6, 2015 letter from A. Thompson to K. DeSalvo). Items like this, therefore, merit direct assessment as part of measuring progress on interoperability.

The AHA recommends that ONC broaden the scope of data sharing it measures beyond solely data that are exchanged. Exchange, or the transmittal of information from one place to another, is an important means of sharing health information and is worth measuring to some extent. However, other mechanisms also can be used to accomplish the goal of ensuring that providers have access to the information they need for care. For example, hospitals and health systems are sharing information with clinicians and post-acute care providers by offering access to shared data systems. This type of sharing can be more efficient and effective than exchange, as the latest data are always available and clinicians with appropriate access rights may access it whenever needed. The RFI does not contemplate this type of sharing, although it clearly fulfills the goals of ensuring data are available for care. We recognize that this type of sharing will be challenging to measure, and may not be available in a quantifiable format. However, we believe that the true extent of information sharing should be reflected in ONC's assessments.

The AHA recommends that ONC look to larger proxies of "use" of electronic health information. "Use" of health information will be challenging to measure, beyond receipt. And, receipt of information does not always equate to use in clinical care. Therefore, it may be more meaningful to look at larger proxies to determine whether shared information is being used for care. For example, hospitals and health systems across the nation are building information systems needed to share the data that will support new models of care. Therefore, expanded participation in alternative payment models (APM) could be considered an outcome measure for interoperability. Those models will only be successful if data are successfully shared. Hospitals are increasingly involved in new models sponsored by the Centers for Medicare & Medicaid Services (CMS), such as the Comprehensive Care for Joint Replacement model, the Medicare Shared Savings Program, the Bundled Payment for Care Improvement initiative, and the more than 50 models currently underway at the Center for Medicare & Medicaid Innovation. Similarly, quality measures already reported should reflect the value of shared health information. For example, recent declines in readmission rates are due, at least in part, to concerted efforts to better share information with ambulatory care providers after discharge.

DATA SOURCES AND MEASURES

Survey data. ONC proposes to use the AHA Health IT Supplemental Survey, a physician survey and metrics from meaningful use as core data sources for measuring interoperability. The AHA has greatly benefited from a strong partnership with ONC in gathering data on hospital use of health IT through our Annual Survey instruments. The survey data we collect are useful and can identify both how exchange is happening and the barriers that remain. For example, in the 2014 and 2015 surveys, we saw dramatic increases in the sharing of health information, and in the ability for patients to access their health information (Figures 1 and 2).

Figure 1. Hospitals show marked improvement in information exchange with care partners outside their system.

Percent of hospitals that electronically exchange clinical/summary of care record in any format, 2011 versus 2015

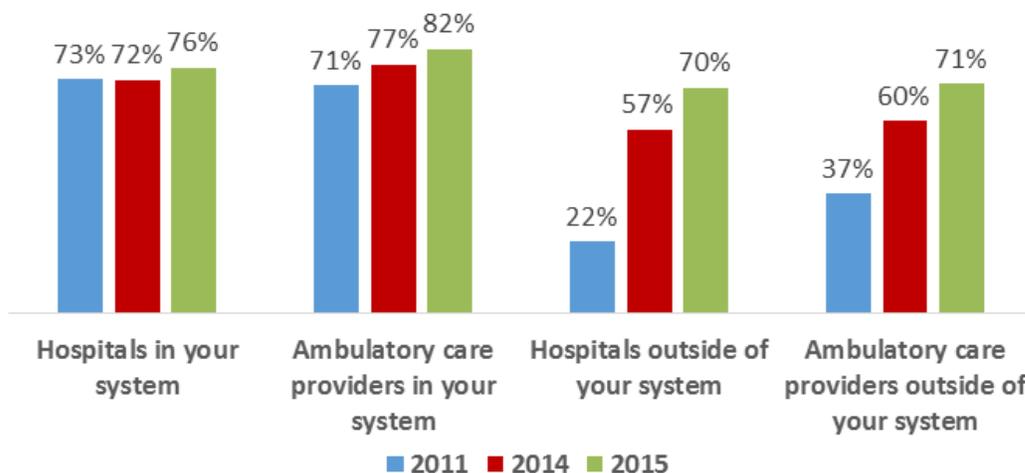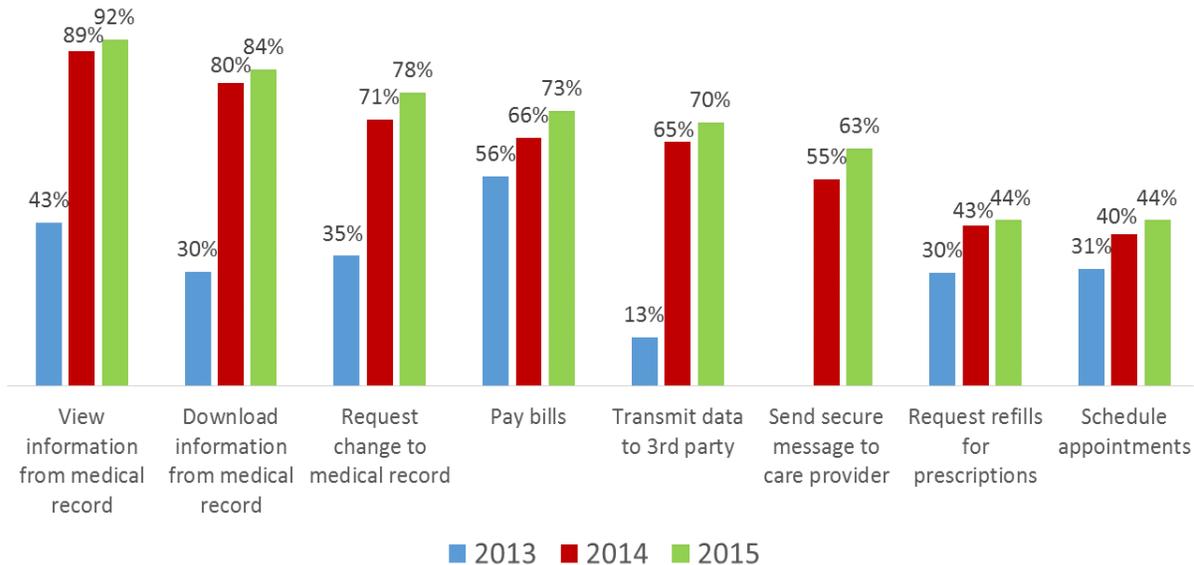|	Hospitals in your system	Ambulatory care providers in your system	Hospitals outside of your system	Ambulatory care providers outside of your system
2011	73%	71%	22%	37%
2014	72%	77%	57%	60%
2015	76%	82%	70%	71%

Figure 2. Hospitals have greatly increased patients' online access to their health information.

Percent of hospitals where patients are able to perform the indicated services online, 2013-2015

Legend: ■ 2013 ■ 2014 ■ 2015

Service	2013	2014	2015
View information from medical record	43%	89%	92%
Download information from medical record	30%	80%	84%
Request change to medical record	35%	71%	78%
Pay bills	56%	66%	73%
Transmit data to 3rd party	13%	65%	70%
Send secure message to care provider		55%	63%
Request refills for prescriptions	30%	43%	44%
Schedule appointments	31%	40%	44%

Meaningful use data on exchange. In addition to survey data, ONC suggests using the data reported under the meaningful use program to inform its assessment of interoperability. The meaningful use measures, such as exchange of a clinical summary for transitions of care, do provide some measurement of exchange. Experience in the field, however, suggests that the type of exchange required for meaningful use is still difficult to do, and many physicians find that the information they receive does not always meet their clinical needs. For example, in the AHA survey data for 2015, the majority of hospitals reported experiencing an issue sending information across settings because their receiving provider either does not have an electronic health record (EHR) (52 percent), or the provider has an EHR but still lacks the capability to receive the data in the specified format (53 percent). For hospitals, these situations often arise with post-acute care providers.

In addition, the meaningful use exchange requirements really only reflect the exchange of a specific electronic document to provide a summary of care, using a specific type of exchange standards. As a result, these measures do not reflect the true extent of information sharing that is happening. Many other types of sharing are occurring, particularly in the context of APMs. Furthermore, if you look across the continuum of care, data are being exchanged electronically by the hospital, received in whatever form is workable for post-acute care providers, but still used to improve care.

Given the many challenges with the types of exchange required under meaningful use, it may be more appropriate to simply look at success with meaningful use, the Merit-Based Incentive

Payment System (MIPS), and alternative payment models rather than assessing specific measures within those programs.

Meaningful use data on use. ONC asked for feedback on whether to consider meaningful use attestation data on "clinical information reconciliation" as a proxy for "use." However, as reflected in our comments on the Stage 3 meaningful use requirements, the AHA strongly opposed the 80 percent threshold for medical record information reconciliation for new patients because the requirement precedes the readiness of patient matching solutions and the availability of EHR interoperability that supports the exchange and use of accurate health information within a recipient's EHR without manual effort. **Given concerns about whether technology will really support clinical information reconciliation, we urge ONC to refrain from using this item as a measure of "use."**

Other provider data. ONC also requested input on whether to use other sources of provider data, such as audit logs, to measure information exchange. **The AHA strongly urges ONC to refrain from considering any new requirements for reporting by providers as a means to measure interoperability.** Given the burden of reporting under the EHR incentive programs, MIPS and other Medicare quality reporting programs, providers cannot sustain an additional "check the box" reporting requirement that is designed solely for the purposes of assessing interoperability. Providers should not be asked to further invest in documenting the extent of exchange at the cost of actually conducting exchange or providing care.

Non-provider data. For the most part, the data sources mentioned in the RFI focus on what providers are doing. **The AHA recommends ONC look more closely at its certification process to determine what information it can get from certified health IT vendors, testing bodies and certification entities about how well certified technology supports interoperability. We also support ONC looking to health information service providers and other health information exchange entities to identify additional data to measure interoperability.** Providers cannot share if they do not have technology that supports efficient and effective exchange. Vendors must be held accountable for making workable and affordable solutions available. Similarly, providers cannot share if the exchange infrastructure is lacking, burdensome to use or unaffordable.

We also recommend that ONC consider convening an expert panel of providers to better understand what information would be helpful to share to support care management and transitions of care. What are the most important use cases from the physician perspective? Are current exchanges working to support those items? This kind of work could move ONC beyond counting "exchange" and "use" to better understanding the needs for information exchange and the ways in which it is happening today.

Widespread interoperability. Finally, ONC asks how the agency should best determine whether the nation has achieve "widespread" interoperability. **Given that our abilities to share information are evolving, the AHA recommends a nuanced view that balances what we have achieved against what is currently possible, rather than a numeric cut-off.** Are we able to share information to meet clinical and patient needs, given the tools currently at our disposal,

and within reasonable levels of effort? Have our technology and exchange partners provided the tools that are needed? If a numeric approach is deemed essential, a simple majority should suffice.

Thank you for the opportunity to comment. The AHA is pleased to partner with ONC on our survey of hospital use of health IT and stands ready to work with the agency as it determines how best to measure progress in achieving interoperability over time. If you have any questions, please contact me or Chantal Worzala, vice president for health information and policy operations, at (202) 626-2313 or cworzala@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development