

PARALLEL PATHWAYS FOR QUALITY HEALTHCARE

A Framework for Aligning Incentives with Quality and Health Information Technology



Recommendations of the
Working Group for Financing and Incentives
eHealth Initiative and Foundation

May 25, 2005

PARALLEL PATHWAYS FOR QUALITY HEALTHCARE

Recommendations of the eHealth Initiative Foundation's Working Group for Financing and Incentives

Executive Summary

The eHealth Initiative and its Foundation launched in December 2004 a diverse group of stakeholders through its Working Group for Financing and Incentives to develop a set of principles and a Framework for incrementally aligning incentives with both quality and efficiency goals and the health information technology infrastructure required to achieve such goals. The Framework, entitled "Parallel Pathways for Quality Healthcare" describes both the enabling HIT infrastructure for physician practices as well as the standards-based connectivity required within regions and communities. The Framework provides a phased, integrated approach that recognizes the varying stages of evolution with regard to regional multi-stakeholder collaboration, focus on quality and performance, and health information technology penetration within markets across the United States.

The following summarizes a set of "Principles for Financing and Incentives" developed by the Working Group:

1. Any incentive program focused on quality should also include some level of incentive—either direct or indirect—for the health information technology (HIT) infrastructure required to support improvements in quality.
2. Any financing or incentive program implemented by either the public or private sector involving HIT should:
 - Result in improvements in quality, safety, efficiency or effectiveness in healthcare.
 - Incentivize only those applications and systems that are standards-based to enable interoperability and connectivity.
 - Address not only the implementation and usage of HIT applications but also the transmission of data to the point of care, both of which are required to support high quality care delivery.
 - Allow for internal quality improvement or external performance reporting as mutually agreed upon by purchasers/payers and providers.
3. Financing and incentive programs should seek to align both the costs and benefits related to HIT and health information exchange.

The following Framework developed by the Working Group, provides guidance to purchasers, payers, practicing clinicians, and regional or community-based collaborations focused on health information exchange who are seeking to improve the quality, safety, effectiveness and efficiency of healthcare in their markets, through HIT and exchange of healthcare data. The Framework provides staged guidance in four focus areas related to aligning goals for quality healthcare: (1) quality capabilities; (2) HIT capabilities within the physician practice; (3) health information exchange capabilities; and (4) financial incentives.

The following summarizes at a high-level the three phases of evolution.

- In Phase I, rewards would primarily focus both on reporting of measures that rely on manual chart abstraction and claims data and physician usage of standards-based, interoperable HIT applications with certain basic functionalities.
- In Phase II, rewards would focus on the reporting of measures that rely on clinical data sources; connectivity of standards-based, interoperable HIT applications to clinical data sources to support information needs at the point of care; and physician usage of HIT with more advanced functionalities.
- In Phase III, rewards would focus on performance against process and outcomes measures, while phasing out rewards for HIT.

It is expected that value will continue to increase through each stage to purchasers and payers who engage in the implementation of the Framework.

We are at a unique point in time, where public and private sector interests are at an all-time high in two key areas: improving the quality and safety of healthcare and moving forward on a health information technology agenda. Approaching these two key issue areas in a siloed manner-- without strong integration across both areas--will result in missed opportunities, unintended consequences, and possibly reduced impact in both areas. By laying out an integrated, incremental strategy, which incorporates goals related to quality, safety, and efficiency as well as health information technology and the mobilization of data across organizations, the principles and Framework included in this document offer the foundation for building a healthcare system that is safer, of higher quality, and more effective and efficient.

PARALLEL PATHWAYS FOR QUALITY HEALTHCARE

Recommendations of the eHealth Initiative Foundation's Working Group for Financing and Incentives

Full Report

Introduction and Background

The eHealth Initiative and its Foundation are independent, non-profit affiliated organizations whose missions are the same: to drive improvement in the quality, safety and efficiency of healthcare through information and information technology. The eHealth Initiative is a multi-stakeholder consortium representing a wide range of stakeholders who share this common goal, including clinicians, health plans, healthcare IT suppliers, healthcare purchasers and employers, hospitals and other providers, laboratories, patient and consumer groups, pharmaceutical and medical device manufacturers, public health agencies, and representatives of state, regional and community-based health information initiatives and organizations.

Reports from a wide range of philanthropic and private sector organizations including the Commonwealth Fund, Institute of Medicine, the Markle and Robert Wood Johnson Foundations, and several non-profit organizations, as well as representatives from the public sector such as the U.S. General Accounting Office, the U.S. Department of Health and Human Services, the U.S. Department of Veterans' Affairs, the Department of Defense, the Medicare Payment Advisory Commission, and several members of Congress, recognize the value of health information technology (HIT) in addressing quality, safety and efficiency challenges in the U.S. healthcare system. Interest has now turned to the development of policies and practices for accelerating the effective implementation and use of such systems in a way that will assure that expected quality, safety and efficiency outcomes will be achieved.

At the same time, the development and implementation of incentives or pay-for-performance programs is on the rise, stimulated by reports from the Institute of Medicine and leadership demonstrated by organizations such as the Leapfrog Group. Pioneering efforts around pay-for-performance are now emerging from Bridges to Excellence (BTE), the Integrated Healthcare Association (IHA), the Centers for Medicare and Medicaid Services (CMS), as well as several other programs initiated by both payers and purchasers. According to one report, almost one-third of health plans say that they now have a pay-for-performance program in place, but most are in the earliest stages of development or implementation.

Pay-for-performance systems provide higher reimbursement for those who perform well on a wide variety of quality, cost and efficiency measures (which are both process and outcome-oriented). Many of these systems have been launched based on the recognition that current reimbursement methods are not effectively curbing both rising healthcare costs and addressing issues related to quality and safety. Many, but not all, of the emerging programs integrate information technology expectations, recognizing that information technology can not only help with the reporting of the quality data typically required for such programs, but can also assist with the achievement of better outcomes—in both quality and efficiency.

While there is recognition of the value of information technology usage by providers and the exchange of information *across* institutions to support a comprehensive view of the patient at the point of care, adoption by providers—in particular practicing clinicians—continues to be low, due to a number of reasons, including the lack of standards and resulting perceived risk of purchase as well as the significant changes in work flow required to move towards implementation. Many believe that the largest barrier to HIT adoption pertains to both the lack of capital to purchase such systems, and even more so, prevailing reimbursement methods which reward volume of services as opposed to outcomes or activities (such as usage of clinical applications) that would result in higher quality, safer, more efficient healthcare. Recent reports from the Markle Foundation's Connecting for Health initiative with additional support from the Robert Wood Johnson Foundation, the Center for Information Technology Leadership, and MedStar Health, as well as ongoing work by organizations like Bridges to Excellence all highlight the issue of misalignment of incentives; i.e. in other words, the economic imbalance that exist between those who purchase HIT (e.g. practicing clinicians, hospitals and other providers) and those who also benefit from its use (e.g. patients, healthcare purchasers, and health plans).

In December 2004, with the support of the eHealth Initiative Foundation's Connecting Communities for Better Health Program conducted in cooperation with the Health Resources and Services Administration, the eHealth Initiative Foundation assembled a diverse group of stakeholders under the leadership of co-chairs Marianne E. DeFazio, CEBS, Director, Global Health Benefits, IBM Corporation and John Glaser, PhD, Vice President and Chief Information Officer, Partners HealthCare System, to launch the Working Group for Financing and Incentives ("Working Group"). The Working Group, which includes practicing clinicians, healthcare purchasers, health plans, healthcare IT suppliers, and hospitals, came together to define a set of principles and strategies for providing financing and incentives to improve healthcare through HIT adoption within ambulatory care.

The purpose of this paper is to summarize key results and findings of the first phase of the Working Group's efforts, including the insights that were gained, a set of principles for financing and incentives, and a framework for designing such programs to align incentives with both quality goals and the HIT infrastructure required by both practicing clinician offices and health information exchange initiatives within markets to support those goals. This framework is currently entitled the "Parallel Pathways for Quality Healthcare" (the Framework).

Overview of the Goals and Objectives of the Working Group

The purpose of the Working Group was to achieve multi-stakeholder consensus on a set of policies and principles for improving health and healthcare by leveraging HIT through financing and incentives, targeting both physician practices and regional and community-based health information initiatives and organizations.

The Working Group and eHealth Initiative Foundation staff conducted a wide range of activities to support this work, including the following:

- Reviewing the experiences of a number of incentives and pay-for-performance initiatives involving HIT that are operating today;
- Reviewing the results of research and initiatives exploring the need for and results of incentives programs and pay-for-performance initiatives; and
- Developing and vetting a set of principles and best practices for incentives with multiple stakeholders across the healthcare system.

Results of our Review

The following summarizes the key findings that emerged from our work.

- **The number of incentive programs for quality and “pay-for-performance” is on the rise.** Over the last several months, the number of incentive and “pay-for-performance” programs has significantly increased, fueled by the recognition that current reimbursement methods are not adequately addressing issues related to quality and safety and rising healthcare costs and signals that the U.S. government is experimenting with similar programs.
- **The value of information technology accrues to many stakeholders.** The value of HIT and health information exchange accrues to many stakeholders including clinicians, health plans, hospitals, purchasers, patients and public health.
- **Coordination and collaboration within the region or community is critical.** Widespread adoption of HIT across physician practices may not be possible without broad-based community collaboration and coordination. Physician practices ordinarily contract with a large number of purchasers and payers. As a result, incentives offered by a small number of purchasers or payers generally are not effective. In addition, most of the data required to deliver care within physician practices resides somewhere else (hospital, lab, pharmacy, health plan, etc.) and therefore collaboration and coordination are necessary to facilitate the transmission of data to the point of care. Coordination and collaboration offer many benefits, including providing leverage to achieve widespread participation, reducing the potential for the “free rider” effect (in which some purchasers and payers reap the benefits of HIT adoption without sharing the costs), reducing the burden created by physician practices participating in multiple reporting initiatives, and significantly reducing the per participant cost of both transmitting and receiving common data elements for various healthcare needs (e.g. healthcare delivery, performance improvement, etc.).
- **Rewards should emphasize the use (not purchase) of HIT applications and eventually focus on performance or outcomes.** Most of the market experiments reviewed initially focused on rewarding the acquisition and use of HIT, sometimes in combination with additional incentives for performance. In some, but not all cases, the reward for acquisition/use was designed to diminish or be eliminated over time, while incentives for performance (i.e., outcomes that are linked to increased HIT use) were designed to ramp up. In many cases, the goal appears to be to reward the innovators who adopt HIT fairly early, in hopes of creating a critical mass and reaching a “tipping point”.
- **Incentive amounts offered should be meaningful.** According to various reports, incentives offered to stimulate adoption and use among practicing clinicians should be meaningful. Many programs have lacked widespread participation due to the level of amounts offered. In one case (Integrated Healthcare Association), the amount of incentive funding tied to HIT was doubled (from 10 to 20 percent of the overall package) after a lukewarm initial response. According to the recent Connecting for Health report on financing and sustainability, such amounts should total anywhere from \$10,000 to \$24,000 per physician per year.
- **Purchaser or payer sponsors of the incentive program should represent a meaningful proportion of the clinician’s patient panel.** Because practicing clinicians often work with a large number of health plans and purchasers, in order for incentives to be effective, they must be delivered by a meaningful proportion of the clinician’s patient panel. This is evidenced in a number of current market experiments. To address this issue, a significant percentage of the purchasers and payers in a market should be recruited to the incentive program to have impact. According to the recommendations of the National Group for the Advancement of Health Information Technology, regional and community-based initiatives should use a combined 50 percent

market share as a target. In addition, the National Group suggests that at least 30 percent (and optimally 50 percent) of a clinician's patient panel should be covered by some combination of participating patients and purchasers.

- **Giveaway programs have had little impact.** Some initiatives reviewed in our work had experimented with giving away applications or hardware (e.g. PDAs, desk top computers) to physician practices, with little impact. Programs in which clinicians have had to invest in such systems have demonstrated greater sustainability.
- **Any applications covered by the program should be "interoperable" and standards-based.** In order to derive the full value of investments in HIT, payers and purchasers should only reward the use of clinical applications that are interoperable, using agreed-upon data standards. Over time, incentives programs should require that the interoperability of such applications is actually leveraged—in other words, the transmission of certain data required for clinical care (e.g., lab, pharmacy, etc.) to the HIT application to support the use of such information at the point of care should be required.
- **Certification and accreditation can offer purchasers and payers confidence.** As purchasers and payers begin to adopt incentive and pay-for-performance programs, they will likely need assurance that systems adopted by physicians are interoperable, functional, and utilized. Several groups have emerged to address these various certification needs including the National Committee for Quality Assurance and the Certification Commission for HIT.
- **Policies related to information sharing should be built into expectations.** As information flow accelerates, it is necessary to establish "rules of the road" for information sharing. The adoption of agreed-upon principles related to the use, access, privacy and security of health information are crucial to assuring public trust in emerging health information exchange initiatives. Connecting for Health is spearheading a collaborative approach for the development of such principles with a delivery date of Fall 2005.
- **Emerging health information exchange initiatives, networks and organizations should be leveraged to facilitate effective and efficient information sharing.** Over the last year, a number of state, regional and community-based multi-stakeholder initiatives have emerged to begin to address the need for information mobility within markets across the country. These initiatives and the organizations that evolve from them should be leveraged to facilitate information sharing and the transmission of data to both physician practices and purchasers and payers participating in incentive programs that need performance data to support their requirements. The National Coordinator for HIT has referenced in its Strategic Framework for Action the creation of organizations that would conduct such activities, calling them "Regional Health Information Organizations" or "RHIOs". The eHealth Initiative Foundation is developing common principles (organizational, legal, financial and technical) for such health information exchange initiatives and organizations through its Connecting Communities for Better Health Program, to provide guidance to and assure public trust in such organizations and initiatives as they develop across the United States.

Bringing it All Together: A Set of Principles and Framework for Implementing Incentives for Higher Quality, More Efficient Healthcare

Based upon the work conducted to date, the Working Group developed a set of high-level principles for financing and incentives and an incremental framework designed to align incentives with purchaser and payer expectations around quality and efficiency as well as the HIT infrastructure—both within the physician practice and across the region or community through health information exchange—to support those expectations.

Principles for Implementing Incentives

The following set of “Principles for Financing and Incentives” were developed by the Working Group:

1. Any incentive program focused on quality should also include some level of incentive—either direct or indirect--for the health information technology (HIT) infrastructure required to support improvements in quality.
2. Any financing or incentive program implemented by either the public or private sector involving HIT should:
 - Result in improvements in quality, safety, efficiency or effectiveness in healthcare.
 - Incentivize only those applications and systems that are standards-based to enable interoperability and connectivity.
 - Address not only the implementation and usage of HIT applications but also the transmission of data to the point of care, both of which are required to support high quality care delivery.
 - Allow for internal quality improvement or external performance reporting as mutually agreed upon by purchasers/payers and providers.
3. Financing and incentive programs should seek to align both the costs and benefits related to HIT and health information exchange.

An Incremental Framework for Aligning Incentives Around Quality and HIT

Early on in the process, participants in the Working Group and several other stakeholders involved in the vetting process, recognized the importance of aligning incentives with not only quality and efficiency improvements in healthcare, but also the HIT infrastructure needed to support those improvements.

Most incentive programs in place today use claims-based information and manual patient record abstraction as the means to determine the quality of care received by patients. There are well researched and documented shortcomings to the use of claims data to determine the quality of care delivered, including the lack of timeliness, in some cases, its inaccuracy, and the lack of its ability to provide important physiological data on patients that are the true markers of clinical outcomes. In addition, manual extraction of data from paper-based charts is time-consuming and expensive. And, according to some reports, charts for patients cannot always be located. The use of clinical applications and health information exchange dramatically increase the accuracy, timeliness, and availability of information to support the determination of quality of care by purchasers and payers administering performance-based incentive programs. The development of this infrastructure also builds the foundation for an evolving set of expectations without building in additional reporting burden.

Finally--and more importantly—the use of clinical applications and the mobilization of patient data through health information exchange also creates the foundation and infrastructure for quality and safety improvement by supporting the provision of important patient information at the point of care and enabling clinicians to improve the quality and safety of care as it is being delivered to patients.

Markets across the country are in various stages of evolution in terms of performance expectations, HIT penetration, and cross-community collaboration. Recognizing these various stages of evolution, the Working Group developed a staged process designed to support a wide range of markets as they transition to an electronic and more performance-based healthcare environment.

The Framework that follows, entitled “Parallel Pathways for Quality Healthcare”, provides guidance to purchasers, payers, practicing clinicians, and regional or community-based collaborations seeking to improve the quality, safety, effectiveness and efficiency of healthcare in their markets through the use of HIT and health information exchange.

The Framework provides staged guidance in four focus areas related to aligning goals for quality healthcare: (1) quality capabilities; (2) HIT capabilities within the physician practice; (3) health information exchange capabilities; and (4) financial incentives.

The following summarizes at a high-level the three phases of evolution.

- In Phase I, rewards would primarily focus both on the reporting of measures that rely on manual chart abstraction and claims data and physician usage of standards-based, interoperable HIT applications with certain basic functionalities.
- In Phase II, rewards would focus on the reporting of measures that rely on clinical data sources; connectivity of standards-based, interoperable HIT applications to clinical data sources to support information needs at the point of care; and physician usage of HIT with more advanced functionalities.
- In Phase III, rewards would focus on performance against process and outcomes measures, while phasing out rewards for HIT.

Ongoing (“ex-post”) incentives that can be utilized for financial incentives include the following:

- Bonus or “add-on” payments—an addition to the normal payment—for HIT in accordance with the criteria included in the Framework.
- A portion of the pay-for-performance incentive is directed to HIT adoption—higher in the early years, lower (and eventually phased out) in the later years.
- Payment for structured e-mail consultations or other telehealth services.
- Chronic care management fees.

Upfront (“ex-ante”) incentives that can be utilized to defray some of the up-front infrastructure costs associated with the initial adoption of standards-based, interoperable HIT, include the following:

- Seed funding provided by governmental, philanthropic or private sector contributors.
- Advance payment of future services from health information exchange initiatives or clearly articulated expectations and commitments from clinicians.
- Low cost or guaranteed loans.
- Tax incentives.

It is expected that value will continue to increase through each stage to purchasers and payers who engage in the implementation of the Framework.

- In the first phase, the staged Framework will enable purchasers and payers to clearly articulate and communicate a common set of expectations through a staged process. The Framework provides clinicians with the tools needed to improve performance in the early years and that ultimately results in payment for outcomes. Immediate gains in quality and safety will be achieved, as documented by several market experiments.

- In the second phase, the efficiency, timeliness, and accuracy of reporting will significantly improve with the reduction in the use of manually extracted chart information and claims data in the calculation of measures and the increase in the use of clinical data derived from electronic sources. The type and number of measures required can be increased based on the more robust HIT infrastructure. Increased gains in quality, safety and efficiency should be achieved given the information available to the clinician at the point of care.
- In the third phase, purchasers and payers can phase out HIT rewards and move to payment based on outcomes and performance. A robust and flexible HIT infrastructure will be in place to support evolving science and changing expectations of purchasers, payers, providers, and consumers.

A detailed overview of the Framework is outlined below.

Area of Focus	Phase I	Phase II	Phase III
Quality Capabilities	<ol style="list-style-type: none"> 1. Create an environment that supports improvements quality and safety. 2. Agree on and report common set of standardized measures to be reported over the three phases based on the National Quality Forum set 3. Leverage claims data and manual chart abstraction 	<ol style="list-style-type: none"> 1. Expand capabilities to utilize clinical information 2. Report measures that leverage expanded clinical data capabilities 	<ol style="list-style-type: none"> 1. Report achievement of certain outcomes and processes
Physician Practice HIT Capabilities	<ol style="list-style-type: none"> 1. Direct usage of HIT by physicians with certain basic functionalities 	<ol style="list-style-type: none"> 1. Direct usage of HIT with expanded functionalities 2. Secure standards-based connectivity between HIT and clinical data sources for lab, prescription and demographic data (health information exchange) 	<ol style="list-style-type: none"> 1. Robust IT-supported clinical environment supporting chronic care management 2. Electronic health record with integrated decision support and ability to accept and integrate structured, computable data from other organizations
Health Information Exchange Capabilities	<ol style="list-style-type: none"> 1. Engage practicing clinicians, hospitals and other providers, purchasers, payers and consumers in health information exchange initiative 2. Launch health information exchange capability using agreed upon technical and information sharing standards 3. Develop sustainable model based on agreed-upon services 	<ol style="list-style-type: none"> 1. Operate secure health information exchange, making available to all authorized healthcare organizations who agree to terms for information sharing 2. Send standardized data to physician practices 3. Send reports of quality measures to purchasers and payers with provider consent. 	<ol style="list-style-type: none"> 1. Expand services to provide value to users as appropriate
Financial Incentives	<ol style="list-style-type: none"> 1. Reward use of standards-based HIT 2. Reward reporting of subset of measures based on data primarily derived from manual chart abstraction and claims. 	<ol style="list-style-type: none"> 1. Reward use of interoperable HIT with connectivity with clinical data sources 2. Reward reporting of expanded set of performance measures that require clinical data sources 	<ol style="list-style-type: none"> 1. Reward electronic documentation of improved clinical outcomes 2. Phase out rewards for HIT
Value to Purchasers and Payers	<ol style="list-style-type: none"> 1. Communicate common set of expectations and incremental roadmap for getting to outcomes 2. Achieve immediate gains in quality 	<ol style="list-style-type: none"> 1. Enhanced efficiency, timeliness and accuracy of reporting 2. Improved ability to target areas in need of focus 3. Significant improvements in quality, safety and efficiency 	<ol style="list-style-type: none"> 1. Full migration to payment based on outcomes 2. Flexible HIT infrastructure to support changing expectations

Stepping through the Process

The following summarizes in detail, the staged approach for aligning incentives with quality and efficiency goals, as well as the HIT and health information exchange capabilities needed to support these goals. As noted above, this incremental, staged approach recognizes the various stages of evolution within each market including the history of regional collaboration, focus on quality and performance and HIT penetration. The phased approach allows for multiple natural experiments to occur throughout the country, to determine the best course of action, based on their current stage of evolution.

Phase I of the Framework

1. *Quality Capabilities*

Phase I of the framework begins to create an environment that supports improvements in quality and safety. The intent of the Working Group is not to create new measures of quality healthcare, but to align with a common set of consensus-based standardized measures developed by others (e.g. the National Quality Forum). The quality expectation in this phase is that providers will electronically report a subset of this adopted full set of quality and efficiency measures. The principle is that providers are not being paid or rewarded for implementing HIT systems in their practices, but they are given incentive to do so because the only cost effective method to electronically produce these clinically oriented quality data in the long run is to implement such systems. As providers become more capable of collecting and transmitting this data electronically, the expectation is that they will report the full set of quality measures adopted at this stage to receive the full range of incentives.

2. *Physician Practice HIT Capabilities*

In the first phase, physicians are expected to directly interact with standards-based HIT systems. These may be self-contained EHR systems, prescription writers, and other forms of electronic record keeping and healthcare process support systems. At this stage, the ability of practices to purchase, install, train, and use HIT systems is very much dependent on a means of justifying a relative large outlay of time and money. Short term incentives can take many forms, but must help to address the bolus of resources required to get set up and started.

3. *Health Information Exchange Capabilities*

In the first phase, diverse stakeholders within the region or community will be engaged to define common principles and priorities for working together. Organizational and legal infrastructures as appropriate, will be developed and information sharing policies will be determined, based on emerging national standards. Technical models for health information exchange will also be launched based on national standards. A sustainable model for the financial and functional health of the health information exchange capabilities will be developed and agreed upon by stakeholders.

4. *Financial Incentives*

In the first phase, providers will be rewarded for the use of HIT to electronically report a subset of quality measures ("pay for quality data"). Although "start-up" incentives can take many forms, it is appropriate, whether they take the form of up-front funding or back-end payment, to base the reward on a common set of criteria that will focus the providers' efforts in the direction of future stages of development. One way to do this is to tie the rewards to the electronic reporting of a subset of predetermined data elements which are thought to be tied to the quality of care. Although at this stage the reward is not dependent on the data showing that the quality of care has been improved, it sets the stage for later phases that do so.

5. Value to Purchasers and Payers

In the first phase, purchasers and payers will be able to communicate a common set of expectations that build over time and establish an incremental roadmap for getting to payment for higher quality outcomes. They will achieve immediate gains in the quality of healthcare delivered and some cost savings, depending on the extent to which HIT resources are implemented and used at this stage, while laying the foundation for a robust infrastructure to support higher quality, more efficient healthcare.

Phase II of the Framework

1. Quality Capabilities

In the second phase, providers are expected to report measures that leverage their expanded clinical data capabilities to document improved processes of care. Reports of clinical lab results that indicate that the percentage of diabetic patients in a practice that has reached a predetermined level of receiving a periodic Hemoglobin A1c test, is an example of the performance improvements that can be documented.

2. Physician Practice HIT Capabilities

Advancement to the second phase of HIT capabilities requires secure HIT connectivity with clinical data sources such as those associated with lab and prescription data. Capabilities must include secure communications with more than one other organization using national standards (labs, pharmacies, hospitals, etc.). These capabilities not only support the needs of purchasers and payers that provide incentives, but also the information needs of clinicians at the point of care.

3. Health Information Exchange Capabilities

In the second phase, a fully operational, secure health information exchange capability is made available to all authorized healthcare organizations who agree to terms of health information sharing. Sending standardized data to physicians (from data sources such as labs, pharmacies, and hospitals) becomes much easier to accomplish. Sending reports of quality measures electronically to purchasers (with provider consent under contract) can be done routinely.

4. Financial Incentives

In the second phase, providers who implement interoperable HIT with connectivity and electronic reporting of a full set of measures, including those that leverage clinical data source, are rewarded.

5. Value to Purchasers and Payers

In the second phase, reporting to purchasers and payers is more accurate, efficient and timely. The ability of the data reporting to target areas in need of focus is improved. Increases in the types and level of data to support improvements should result in considerable improvements in quality, safety and efficiency.

Phase III of the Framework

1. *Quality Capabilities*

In the third phase, providers are required to achieve certain process measures and outcomes to receive rewards. Having built the health information infrastructure with incentive support in Phases I and II, the provider has many of the tools necessary to support a transformed care delivery process.

2. *Physician Practice HIT Capabilities*

Movement to the third phase requires a robust IT-supported clinical environment that supports clinical decision support and chronic care management. The provider's electronic health record must integrate decision support and have the ability to accept and integrate structured, computable data from other organizations. It should be noted that Phase III provides the opportunity to remove the artificial barrier between clinical systems and administrative (billing) systems.

3. *Health Information Exchange Capabilities*

In the third phase, health information exchange initiatives and organizations can expand services to support physician adoption of HIT and quality improvement. Examples include the provision of electronic access to evidence-based, national clinical decision support rules (for integration with computer aided decision support systems in EHRs).

4. *Financial Incentives*

In the third phase, providers are rewarded for the electronic documentation of improved clinical outcomes as well as progress against process measures. Purchasers and payers begin to phase out rewards for HIT given that most of the HIT infrastructure has already been developed and that getting to this phase requires providers to effectively utilize interoperable, connected, clinical applications.

5. *Value to Purchasers and Payers*

The third phase enables full migration to payment based on outcomes. It also enables a flexible HIT infrastructure to support changing expectations (different or expanded measures). It should be noted that the infrastructure required in the third phase has the opportunity of enabling payers to move "coding" for reimbursement into their adjudication processes through automation based on actual clinical documentation. Re-engineering of reimbursement systems could result.

Summary

Creating pay-for-performance and other incentive programs in the marketplace that are not consistent with the principles in this document can have negative consequences. Without common, agreed upon pathways for moving forward, the transition of physician practices towards electronic systems along with increasing performance expectations will be confusing, difficult and costly. Providing a process that clearly communicates purchaser and payer expectations over time using a staged approach will help clinicians anticipate, prepare and build the infrastructure required to achieve those expectations over time.

Providing incentives for quality and efficiency without at the same time, supporting the development of the HIT within physician practices and health information exchange capabilities within regions and communities to support improvement will result in the creation of siloed systems that might be quite effective in producing performance reports, but are not conducive to providing information back to providers where it is needed most—at the point of care. In addition, providing incentives for HIT alone, without connectivity

expectations, has the potential of simply automating the highly fragmented, paper-based, ineffective system that exists today, wasting limited resources.

It should also be noted that the HIT and health information exchange capabilities described in the Framework are suitable for many needs, including those related to population and public health, provision of patient-centric health information to consumers, clinical research, performance reporting, and most importantly—delivery of healthcare. All stakeholders within healthcare should strive to move towards a common system—decentralized but based on national standards and policies--to support our nation's health and healthcare needs.

Next Steps: Where Do We Go From Here?

The eHealth Initiative and its Foundation intend to expand upon and accelerate the adoption of the principles and Framework developed by the Working Group through a wide range of activities in 2005 and 2006.

- 1. We will further develop the principles and policies contained in the Framework.** This work will be conducted through eHealth Initiative Foundation's various stakeholder-focused working groups, including the Working Group for Small Practices, the Employer Purchaser Advisory Board, and the Working Group for Connecting Communities (which is made up of state, regional and community-based health information exchange initiatives and organizations). In addition, a health plan-focused group will be organized to facilitate significant input from and collaboration with payers in the enhancement of the Framework.
- 2. We will translate the principles and policies contained in the Framework into practical "how to" guides, detailed policies, and tools** that will support understanding and implementation by healthcare purchasers, business coalitions, health plans, practicing clinicians, and health information initiatives/organizations in markets across the United States. One of the tools that will emerge from this work will include detailed technical specifications (using nationally accepted data standards) for ambulatory performance measures that are emerging from the National Quality Forum's consensus process. We will also develop various tool-kits and guides to support the implementation of those measures both within physician offices and by health information exchange initiatives. The guides and tools developed will leverage the work of Federal agency-commissioned projects related to standards, the work of Connecting for Health and other national standard-setting initiatives both within the public and private sectors and be supported by eHealth Initiative Foundation's various stakeholder-focused working groups, including the Working Group for Small Practices, the Employer Purchaser Advisory Board, and the Working Group for Connecting Communities.
- 3. We will support implementation through both funding and providing technical assistance to a set of pilot projects or "market experiments"** that test and evaluate various components of the Framework. These same pilot projects will also implement and evaluate the technical and information sharing policy deliverables that emerge from Connecting for Health. This work will be conducted through the eHealth Initiative Foundation's Connecting Communities for Better Health Program. The challenge award process will be announced this summer.
- 4. We will conduct working meetings and symposia designed to facilitate dialogue and learning** among healthcare stakeholders that are experimenting with incentives around quality and HIT in their markets to further inform and enhance the Framework, through the Working Group for Financing and Incentives.

5. **We will utilize the policies and principles contained within the Framework to inform emerging policy vehicles** at the Federal and State levels, through eHealth Initiative's Policy Working Group. It is anticipated that a number of policy vehicles will emerge during 2005. We will work to educate policy-makers on the principles and components of the Framework to assure that goals around HIT and quality/safety are integrated.
6. **We will utilize the insights gained from each of the above-identified activities to enhance the Framework** through the Working Group for Financing and Incentives. The Working Group will continue to serve as the "hub" for this work, synthesizing the input and learning derived from each of the above-identified activities, to continually enhance the Framework and principles.
7. **We will widely disseminate the Framework**, through a wide range of vehicles including eHealth Initiative's diverse and influential membership, AHRQ's National Resource Center for Health Information Technology, targeted outreach to key groups and associations, eHealth Initiative's Connecting Communities for Better Health Program conducted in cooperation with DHHS; our State and Regional HIT Policy Summit Initiative; targeted outreach to policy makers at the federal and state levels, and general public relations activities.

Conclusion

We are at a unique point in time, where public and private sector interests are at an all-time high in two key areas: improving the quality and safety of healthcare and moving forward on a health information technology agenda. Approaching these two key issue areas in a siloed manner-- without strong integration across both areas--will result in missed opportunities, unintended consequences, and possibly reduced impact in both areas. By laying out an integrated, incremental strategy, which incorporates goals related to quality, safety, and efficiency as well as health information technology and the mobilization of data across organizations, the principles and Framework included in this document offer the foundation for building a healthcare system that is safer, of higher quality, and more effective and efficient. In addition to offering guidance to stakeholders involved in these two areas of interest, it also develops a framework for dialogue regarding how incentive programs can be designed for integration.

Over the coming months, the eHealth Initiative and its Foundation will work closely with all key stakeholders—including practicing clinicians, purchasers, health plans, hospitals, healthcare IT suppliers, consumer groups, policy-makers at the national and state level, and other key constituencies, as well as other non-profit and government groups focusing in this area—to further develop the Framework and principles, test their effectiveness in markets across the United States, and widely disseminate their results to build awareness and support implementation.