IT Infrastructure, Physician Leadership Critical for ACO Success

By Rebekah Apple, MA

In this article...

Take a look at the challenges that three Pioneer ACOs encountered as they developed their business models in 2012.

After announcing its Innovation Center’s Pioneer ACO Model initiative in 2011, the Centers for Medicare and Medicaid Services received more than 160 letters of intent and more than 80 applications for participation.

Once the first performance period began in January 2012, and again at the beginning of this year, ACPE reached out to three of the 32 systems that demonstrated the acumen and promise sought by CMS: Eastern Maine Healthcare Systems (EMHS), HealthCare Partners Medical Group California and Franciscan Alliance. The conversations quickly revealed a common thread—unequivocally, information technology is the most perplexing and fundamental facet of not only launching, but also maintaining, a successful ACO.

Each of the three participants also iterated the significance of physician leadership during planning, implementation and day-to-day operations. In the world of ACOs, physician leadership necessarily extends beyond the traditional roles into information technology; CMIOs sit at the ACO’s structural core, facilitating safety and quality within a new paradigm.

“It’s a different ball game,” says William Chin, MD, executive medical director of HealthCare Partners. “Whoever takes that first step will show others it can be done.”

Mike Donahue, MBA, serves as vice president of payer contracting and relations for EMHS. Donahue credits the CMIO with keeping physicians actively engaged and recalls with clarity the system-level honing and solidifying of the IT infrastructure. “The CMIO position was a natural evolution. It starts with someone doing the job part time then becomes three-fourths time, and so on.”

These endeavors helped pave the way for what Donahue credits as a major factor in EMHS’ selection for participation in the Pioneer ACO Model: their receipt of the Beacon Community program grant in 2010. Chosen by the federal government as one of 15 pilots throughout the country, EMHS received funding to assist in the development of measurable improvements in health care quality, safety and efficiency.

The award allowed for a substantial investment in IT and played an important role in distinguishing the system throughout CMS’ competitive application process. “When Bangor was selected as a Beacon Community, we then had resources to begin a lot of this,” he says. “We could bring on care managers and establish a number of things that allowed us to be so well-positioned (for the Pioneer ACO Model).”

IT challenges

According to Donahue, the IT complexities involved in an ACO cannot be overstated. Cross-organizational collaborative care is the only way for an ACO to achieve improved outcomes and reduced costs. This goal, reminiscent but far broader in scope than that of EMR implementation, represents the largest financial investment for organizations seeking to implement an ACO. EMR technology, designed for use within an organization’s borders, becomes just one tactic within the elaborate strategy of integration known as the Health Information Exchange (HIE).

In January 2012, representatives from each EMHS practice and IT staff were meeting weekly to address large-scale, burgeoning change. The system had been laying groundwork for years, and progressed from an organization in which physicians expressed initial concern about EMR demands on their time to one where physician leaders played a pivotal role in preparing for the oncoming shift.

By 2012, overall, Donahue believed the culture was ready. “We have a good cadre of physician leaders who really bought into the concept. There was a history of a lot of collaboration, transparency. We were ready for it and had physician membership who were committed and understood the need.”
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Significant physician leader input, according to Donahue, results in increased trust and better results. Donahue believes in two keys to success:

- Ensuring a solid administration/physician leader dyad.
- Maintaining a strong physician leader component within administration itself.

“You can implement any number of EMRs and some may be better than others, but even with the best in the world, if there’s resistance on the part of physicians, it’s not going to make any difference.”

‘HIPAA on steroids’

With 2013 just under way, Donahue characterizes their IT as “HIPAA on steroids.” As anticipated, EMR implementation proved itself the foundation of a “layer cake,” and the team dedicated to driving IT efficiency continues to meet, now once monthly. Its participation in the Pioneer ACO Model reveals the need for continuous measurement related to optimal use, as well as additional technology.

“We now need to address new situations such as partners who have different systems, and some don’t have a disease registry, so how do we track that? IT remains a massive commitment.”

As they work toward developing standardized data and effective

### United States — EMRAM

<table>
<thead>
<tr>
<th>Stage</th>
<th>Cumulative Capabilities</th>
<th>2012 Q3</th>
<th>2012 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 7</td>
<td>Complete EMR; CCD transactions to share data; Data warehousing; Data continuity with ED, ambulatory, OP</td>
<td>1.8%</td>
<td>1.9%</td>
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<tr>
<td>Stage 6</td>
<td>Physician documentation (structured templates), full CDSS (variance &amp; compliance), full R-PACS</td>
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<td>Stage 5</td>
<td>Closed-loop medication administration</td>
<td>12.0%</td>
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<td>Stage 4</td>
<td>CPOE, Clinical Decision Support (clinical protocols)</td>
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<tr>
<td>Stage 3</td>
<td>Nursing/clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology</td>
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<td>38.3%</td>
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<tr>
<td>Stage 2</td>
<td>CDR, Controlled Medical Vocabulary, CDS, may have Document Imaging; HIE capable</td>
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<td>10.7%</td>
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<tr>
<td>Stage 1</td>
<td>Ancillaries - lab, rad, pharmacy - all installed</td>
<td>4.8%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Stage 0</td>
<td>All three ancillaries not installed</td>
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<td>8.4%</td>
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</table>

Data from HIMSS Analytics® Database ©2012

N=5319  N=5458

PLEASE NOTE: These graphics are an abbreviated version of the HIMSS Analytics EMR Adoption Model. All organizations must secure permission to post our model on any public notices, and to obtain their score they must complete the HIMSS Analytics study before validation of their score.
IT isn’t a panacea.

management, Donahue feels physicians have become better positioned to take on leadership roles. He points to increased transparency and the role physician leaders play in sharing information with other clinicians—essentially taking advantage of the ability to speak the same language.

“We wouldn’t be able to move forward without them,” says Donahue. “Their roles, day to day and long-term are critical.” They now function in a rapid-cycle improvement environment, with new requests coming every day.

Chin reiterates the integral nature of physician leadership within the Pioneer ACO Model. “Without it, you’re not going to succeed. They’re crucial to all of the elements that drive success—quality, patient satisfaction, improving all of that—it’s the physician who drives those areas.”

With a stable of 650 physicians in California, Chin did not have to look externally to gather talent. He identifies a gap analysis as the first— and hardest—step in ACO-building. “In every geographic region, they will have a slightly different focus. We only posed questions about what needed to be improved to the physicians. We didn’t go to the operational team until we had the ideas from the physicians. The important ideas emanate from the doctors themselves.”

HealthCare Partners Medical Group California “tweaked, rather than rebuilt” its infrastructure to qualify for the program. The organization’s historic investment in EMR includes a physician responsible for medical informatics and another focused solely on improving functionality and linking IT with physician work flow.

Certainly, the organization has leveraged its considerable size to achieve IT goals, such as a robust data warehouse and the ability to bring its group-side EMR to the IPA. Like Donahue, Chin sees the propensity of IT roles to evolve over time to meet need. “What happens is, you’re able to solve some IT stuff,” Chin notes. Before you know it, “you’re in IT.”

Data issues

Six months into the program, Franciscan Alliance CMO Albert Tomchaney, MS, MD, MMM, FAAFP, reported the organization was still working through considerable data issues, such as transforming data “into actionable items, developing and evolving a more integrated delivery system.”

Like Eastern Maine, Franciscan Alliance consistently utilized IT as a method to reduce costs and variation, and has been doing so since 2008 (also with a CMIO in position since then). It also believes in cultivating collaboration and flexibility. “We have a number of different kinds of innovative relationships with medical staff.”

At Franciscan Alliance, involving physician leadership across the spectrum of activities is a matter of course. “It’s critical,” acknowledges Tomchaney. “Whether they’re employed or not, the engagement of physicians in a real, active way in the redesign process is critical.”

The organization saw the Pioneer ACO Model as an opportunity to add more physician leaders within the practices and enhance the roles—and, therefore, participation—of the vice presidents of medical affairs and chief medical officers. As excitement around the model grew throughout the organization, it led many clinicians to become more involved in administration and their voices were predominantly well-received by other physicians. Tomchaney identifies these individuals as “physician champions.”

At the start, physician leaders recognized the need for an infusion of additional leadership, such as chief nursing officers, and Franciscan Alliance continually works toward the goal of “breaking up the silos … activities to enhance the experience for everyone, particularly the physicians,” to ensure ACO success.

Redesign on the practice level began with an IT facilitator focusing on meaningful use. “We used that as a template to really change the dynamic of the patient’s experience.” In mid 2012, IT continued to present the greatest demands.

“We did have to hire in care management, and we had to go and get folks with expertise in advanced models … (but) you just can’t find enough of the IT professionals you need for these systems. Right now that’s the challenge.”

Tomchaney doesn’t feel this struggle is unique to those participating in the Pioneer ACO Model. “Across the country, everyone is trying to jump on IT platforms, and they’re all having the same issues with resources and shortages.” The infrastructure, says Tomchaney, is something that is “never implement ed as quickly as you need. You always discover work flow or connectivity or interface issues.”

He stresses that IT isn’t a panacea. The “garbage in, garbage out” concept heavily applies. Systems require purposeful effort to develop and prove worth; those efforts require many hands on deck.

For those organizations just starting out, Tomchaney recommends an approach similar to Chin’s: first, identify inadequacies. “Address it sooner rather than later,” Tomchaney says. “You might not have enough people where you are able to just turn on the system, or enhance your current system. Look at IT resources very carefully.”

What does the future hold?

Midway through January 2013, Tomchaney expresses pride at the progress the system made over a
six-month period. “We didn’t underestimate the technology, but it’s been overwhelming.” He has found the experience intense and rewarding and, at their current stage, doesn’t believe their CMIO’s value could be exaggerated. “We need about five of him,” he acknowledges.

One main advantage provided by the CMIO is his ability to elucidate the end-point of refinements to both clinicians and administration. Serving as a link between the two parties, Tomchaney says the CMIO thinks long term. “He can talk to the physicians at every stage about what may or may not work.”

Like their Eastern Maine counterparts, clinicians at Franciscan Alliance expressed skepticism regarding the technology in the beginning. Now they’ve experienced benefits from the architecture and look forward to total standardization. He continues to highly value the physician champions. “They are the ones who envision the future and help encourage others.”

The experiences of Eastern Maine Healthcare System, HealthCare Partners California and Franciscan Alliance may not be the same as their 29 peers in the Pioneer ACO Model; non-participating organizations moving forward with their ACOs may not find opportunities and challenges mirroring the three systems, either.

The layer cake analogy offered by Donahue, however, holds true in health systems across the country. He refers to the ever-expanding technical needs as “peeling back the onion.” There are always improvements on the horizon and, even after the identification of IT disconnects, it can take years to address each one of them and arrive at a point where, as Tomchaney describes, “there is a light consisting of patient-centered, population-based health care at the end of the tunnel.” The weight of integration, data analysis and coordination of care remains on the health information exchange.

In a December 2012 Healthcare Informatics interview, Jane Metzger, principal researcher of the Emerging Practices Group for Computer Sciences Corp, said, “Large-scale HIE is based on the premise that participating entities have systems in place that can send and/or receive the needed information; we’re so far from that today that I think it is more realistic to work incrementally toward broader and deeper HIE.”

Echoing Metzger’s observations, the number of tasks still being completed manually at Tomchaney’s organization is significant; he estimates there remains up to two years’ worth of work to arrive at the point that “everyone idealizes.” When asked to reflect upon the progress of other participants in the model, as well as systems currently ramping up their programs, Tomchaney observes, “An organization like HealthCare Partners Medical Group California has been taking those incremental steps for years. For those who haven’t, it will be a more daunting process.”

Anil Kottoor is president and CEO of MedHok Healthcare Solutions, a Florida-based software company with an Integrated Actionable Healthcare (IAH) platform. Although its primary customers are government-sponsored health plans, the firm is seeing an increase in hospital/organization clients. He believes in the importance of a talented CMIO, both in terms of management and strategy, as it relates to developing a successful HIE and, based on his research and experience, thinks “20 percent of the hospital market has a solid plan for implementation and another 40 percent are putting processes in place” for real solutions.

Although heterogeneous, with some still experiencing growing pains, Pioneer participants exemplify CMS’ communicated, long-term expectations; CMS selected systems mature enough to mitigate risks inherent to the model. Their maturity becomes acutely apparent upon review of EMR adoption data in the U.S.

In 2006, HIMSS Analytics developed the Electronic Medical Record Adoption Model, classifying the progress and levels of EMR capabilities of more 5,300 hospitals and health systems in the United States. Eastern Maine Medical Center ranked Stage 6 with 1.8 percent of the respondents; in January 2013 Franciscan Alliance also operated at this level of functionality.

With $1 billion dollars in incentive payments paid to hospitals in December 2012 alone, the trajectory is obvious. And in early January 2013, Medicare announced 106 new ACO contracts. The curve is steep, and the 32 originally selected organizations for the Pioneer ACO Model were forerunners. Their experiences offer meaningful insight to those systems working toward meeting the guidelines.

Says William Chin, “The information on the elements is already out there. You just have to start. If you wait until you’re ready, it will be 10 years from now.”

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