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DAVID F. CARR
@davidfcarr

Truly engaging with patients online is widely perceived to be one of the biggest hurdles that healthcare organizations face. Putting up a portal and giving patients a password isn't hard, but getting patients to use it? Hospitals and healthcare organizations have enough of a challenge getting their employees and affiliated doctors to use online tools. Patients are outside their control, so how are they supposed to meet the patient-engagement performance targets baked into Meaningful Use, Stage 2?

It's called marketing, folks. Make patients an attractive offer that they will perceive to be in their own best interests, and hold onto them by offering superior convenience and overall service. They're not just patients anymore. They're also consumers and, increasingly, customers, and any good business knows how to attract and retain them.

One of the themes of last month's eHealth Initiative conference in Orlando was that healthcare is shifting from a business-to-business to a business-to-consumer model. No coincidence that the event's opening keynote speech was by Joshua Riff, the medical director who oversees Target's in-store clinics as well as programs for keeping the retailer's employees healthy.

When healthcare organizations talk about becoming more patient-centric, that sounds like a noble aspiration. But it's also a business imperative. For a long time, the US system of employer-sponsored healthcare was built around a business-to-business model, whereby the main customer of a medical practice or hospital was an insurance company, not the patient, and the insurance company's main customer was the employer. Or the customer was a government program like Medicare or Medicaid, with the bill going to taxpayers. This pattern of indirect funding has come to be seen as one of the flaws in the system, leading to higher costs because patients feel entitled to whatever care their provider recommends, at whatever cost.

The trend toward individuals taking more control over and responsibility for their healthcare expenses has been gaining momentum for decades, but it's accelerating because of the Affordable Care Act, as well as pressure from employers seeking to contain health insurance costs. Health insurers are selling directly to individuals through the Obamacare insurance exchanges. More employers are having their employees and retirees select their plan from a menu of choices offered through a private exchange. People shopping for the best price often find their way into a high-deductible plan, meaning that a bigger portion of the bill for any given healthcare service will be paid by the individual. The very deliberate intent of this structure is to make consumers more price-sensitive, making it ever more important that healthcare organizations sell consumers on the value that they offer.

"We're forcing them, unwillingly in some cases, to accept more financial risk in return for their care," says Sam Ho, chief medical officer and executive VP at UnitedHealthcare and the new chairman of the eHealth Initiative. The restructuring underway is radical and the implications for health information technology are equally profound. "We're changing the entire customer service model," he says. Health IT systems need to be able to integrate that customer model with quality data, clinical decision

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support, and patient-engagement strategies to produce a better customer experience.

More Risk

Like their patients, provider organizations are taking on more risk when they participate in the Medicare accountable care organizations created under Obamacare. ACOs are healthcare networks in which providers are compensated based on how well they care for an entire population of patients, as measured by the outcomes of care provided, rather than by how many patients they see. The federal government is also phasing in a system of penalties to be deducted from Medicare reimbursements for excessive hospital readmissions, the idea being to encourage hospitals to get the job right the first time and do a better job of follow-up to make sure patients are complying with doctors' orders.

One important enabling technology for ACOs is the patient portal and other techniques for patient engagement. To improve health outcomes, providers want to get patients more involved in their own care. Furthermore, with the incentives aligned for providing care at a lower cost, providers want to encourage preventative health measures that will eliminate the need for a hospitalization. New modes of patient interaction such as video consultations, which might not always be reimbursed under the conventional fee-for-service model, can also make sense once the goal is to deliver the best results for the lowest cost.

One of the salient features of the Medicare program is that participating hospitals and healthcare networks are assigned a pool of Medicare recipients to care for — patients who have used their services in the past — but the patients aren't required to get care only from within the ACO.

"We're trying to reap a health improvement, but patient engagement doesn't mean patient accountability," says William A. Spooner, CIO at Sharp HealthCare in San Diego, who spoke on an eHealth Initiative panel about technologies to support population health. Under Obamacare rules, providers and payers aren't allowed to discriminate against the person who smokes, never exercises, and is in poor health for those reasons. The most they can do is try to motivate them toward better habits. Similarly, Sharp's Medicare ACO can analyze all the data it has gathered about a patient and use it to formulate a care plan, but it can't prevent the patient from going to a hospital or physician outside of its network that might not follow that plan.

That's one reason Sharp has put a lot of energy into developing its patient portal, and into making it a pleasant consumer experience and CRM system as well as a patient-engagement tool. Part of its purpose is to keep patients in network.

"Given I can't make them accountable, I've got to be able to attract them. I have to show them we're the most viable provider in town, so they want to come to us," Spooner says. Obviously, healthcare providers need to get lots of other things right in order to gain patient loyalty. But in terms of what an IT organization can do to steer things in the right direction, focusing on the patient-engagement experience becomes very important. In the online world, marketing and service delivery are one and the same.

David F. Carr is editor of InformationWeek Healthcare. Share a digital version of this story and read others here. Write to him at david.carr@ubm.com.

Health IT In The Obamacare Era

Modern technology created the opportunity to restructure the healthcare industry around accountable care organizations, but IT priorities are also being driven by the shift.

By David F. Carr @davidfcarr

Despite all the attention focused on health insurance reform by the problematic launch of HealthCare.gov, the biggest impacts on healthcare organizations are likely to come from other measures embedded in the 906 pages of the Affordable Care Act legislation that squeaked through Congress in 2010.

Obamacare endorsed a structural change in the way hospitals and healthcare organizations get paid, based on how well they keep a given population of patients healthy rather than the number of patient visits or procedures

they perform. This twist on the concept of managed care, known as an accountable care organization (ACO), is a strategy for improving the cost-to-value structure of Medicare. And it's expected to have technology and other ripple effects throughout the healthcare and insurance industries.

How quickly and completely this transformation will occur is debatable. Most of the people we interviewed see it as inevitable but likely to take a decade. Yet because this transition will rewrite the rules of care delivery and billing, organizations will have to make countless information systems changes to compete effectively as ACOs. For example, Sharp HealthCare in San Diego, which participates in both government and commercial ACOs, is working through at least half a dozen major system changes in order to support ACOs effectively (see story, p. 8), says CIO Bill Spooner.

Care management is "like CRM for healthcare."

— Bill Spooner, CIO, Sharp HealthCare

In some ways, ACOs are reminiscent of the health maintenance organizations (HMOs) that arose in the 1970s. "They failed in large part because there wasn't any data," says Cynthia Burghard, an analyst who covers healthcare IT at IDC. Early managed care efforts talked about encouraging preventive care, but they focused mostly on containing costs. They introduced "capitated" models, limiting how much a provider could get paid for a given type of care, without providing tools to help providers become more efficient, Burghard says.

Today, the lack of data isn't a problem, though making effective use of it can be.

A few provider organizations such as Partners HealthCare have already shown that it's possible to find an ACO win-win by generating millions of dollars in Medicare "shared savings" to be split with the federal government. Yet others are frustrated by the lack of results they've been able to achieve through that same program, and nine of the 33 institutions that Medicare picked as its Pioneer ACOs dropped out of the program last year.

This is the "Obamacare era" of regulatory

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change, though some elements are really a continuation of policies initiated under the Bush administration. President George W. Bush started what became the federal government's Meaningful Use program, promoting the use of electronic health records and other health systems. Funding for Meaningful Use arrived in the HITECH Act, which was part of President Obama's 2009 economic stimulus program.

While Meaningful Use and the Medicare ACO program are the result of separate legislation, ACOs aim to take advantage of a modernized health IT infrastructure and exploding volumes of data being gathered, while at the same time putting pressure on IT pros to improve those technologies and analytics.

The broader trend is called population health management — the idea that by focusing on improving the health of entire populations of individuals, healthcare organizations can deliver better care, more cost effectively. One way to drive that change is to move away from the traditional fee-for-service model, whereby healthcare providers can earn more from sicker patients who require more office visits, hospital admissions, and surgical procedures.

Reformers refer to these as "perverse incentives" that drive overutilization, resulting in episodic "sick care" rather than a systematic effort to improve people's health. If what we want instead is a healthcare system that makes people healthier at a reasonable price, the incentives should reward preventive care that reduces the need for those visits, admissions, and surgeries.

The ACO concept has been kicking around since at least 2006, when it was introduced as a Medicare reform proposal. The first ACOs actually came from private insurers, while lawmakers and regulators mulled over the idea. Now, because the government's Medicare program is the largest insurer of all, its endorsement of the ACO model reinforces the idea that this is the wave of the future.

"If Obamacare does anything, it encourages people to get coordinated more quickly," says David Muntz, a former deputy director of the Office of the National Coordinator for Health IT, which oversees the Meaningful Use program. Muntz now serves as senior VP and CIO at GetWellNetwork, an online service focused on boosting patient engagement. Organizations may be changing because they see the benefits of accountable care or because they're "trying to survive in spite of it," but they will all have to change, he says.

"The ACO model was a logical outgrowth of the challenges we were seeing on the financial side of the business," Muntz says.

Surviving Accountable Care

Whether intended or not by lawmakers, the new regulatory regime may also drive further

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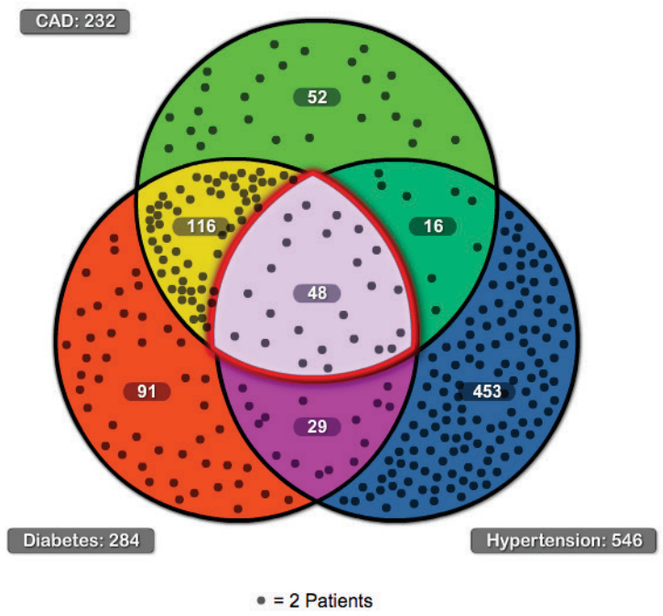

This Venn diagram visualization, showing the overlaps between populations of patients with coronary artery disease (CAD), diabetes, and hypertension (high blood pressure), is from ForwardHealth Group's PopulationManager, one of the new analytic tools targeting the needs of ACOs and population health programs. In this case, the goal is to identify patients who have more than one of these chronic conditions so their overall care can be managed more effectively.

industry consolidation, since sole practitioners and small practices will find it even harder to compete with large organizations that can assert more comprehensive control over patient care. If providers are asked to take responsibility for all aspects of a patient's care, they'll want to have control over as much of it as possible.

That consolidation is already happening, Muntz says. "Providers who are weary of the changes or don't want to take the time to understand all the changes are lining up with hospitals," he says. Remember, he adds, "we're still supposed to be focused on the patients. It's not all about the money — it's how do you get the patients engaged in their own care?" If the structural changes in the market achieve a better quality of care, he thinks the transition will have been worthwhile.

When hospital CIOs talk with Muntz about the pressures they're facing, they talk less about Obamacare than about their organizations assuming more risk in general, dealing with both public and private payers. That means they need to do a better job of coordinating care across all the doctors and nurses in their networks, as well as with the patients themselves, he says.

As a former hospital CIO, Muntz says he regrets the collective effect of piling so many

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PROVIDERS

Technologies For Accountable Care

Here are some of the technologies healthcare providers must implement or improve to function as accountable care organizations.

Electronic health records: In an ACO, the use of EHRs is no longer optional. Outside of closed, integrated healthcare providers, several EHR software products will likely be in use. For efficient ACO operations, IT leaders will want to at least limit EHRs to a small number of interoperable systems.

Health information exchange: Participants in an ACO must be able to exchange data with one another and with organizations outside of their ACO network. Health information exchange is both a noun and a verb; state and regional HIEs act as intermediaries for transmitting health data and addressing interoperability issues, but there are alternate modes of exchanging health, data such as the Direct protocol for secure email attachments. Either way, ACOs must figure out how to make it happen.

Patient engagement: Healthcare organizations are trying to engage patients online as part of a strategy to qualify for federal Meaningful Use incentive dollars. For ACOs, patient engagement is a much more central concern, a way to get patients more involved with their own care to lower costs and achieve (depending on the ACO reimbursement structure) either "shared savings" or profitable operations for a fixed per-patient fee.

Analytics and dashboards: Managing a whole population of patients requires an understanding of its members, their average health, and the financial risk associated with their care, as well as the health challenges of individuals and the intervention strategies that could make a difference for them.

Clinical decision support: By providing better evidence-based guidance to physicians, ACOs aim to deliver proper care the first time, achieving better prevention and reducing the incidence of hospital readmittance.

Care management: The care experience needs to be unified across providers, facilities, and IT systems. Systems should help track tasks, create and manage care plans, track events, and schedule appointments and reminders. Such tools should be able to generate both personalized care plans and broader campaigns addressed, for example, to all diabetics.

Videoconferencing and remote patient monitoring: ACOs can capitalize on technologies that support care at a distance, working within a reimbursement scheme tied less to traditional office visits and hospital admissions.

Revenue cycle management: ACOs are set up to minimize, if not eliminate, the fee-for-service basis of healthcare delivery in favor of payment for the quality of care delivered. That means retooling billing systems to account for metrics other than office visits and medical procedures. *— David F. Carr*

requirements onto technology managers at once. "If all they had to do was Meaningful Use, it would be fairly straightforward," he says, but the steeper requirements of Meaningful Use Stage 2 are hitting at the same time as many other requirements, such as the shift to ICD-10 coding and the need to adapt to accountable care. Big hospitals may be up to it, but smaller and rural providers are struggling. "On the other hand, if we hadn't put a stake in the ground, would they have moved at all?" he says.

"You can't buy, quote, a 'population health management tool,' because it isn't one tool. It isn't a module."

— James Noga, CIO, Partners HealthCare

The ACO Pioneers

Partners HealthCare is one of the big organizations that seems to be up to the challenge.

The Centers for Medicare & Medicaid Services picked Partners as one of its Pioneer ACOs, organizations charged with proving the value of the model and attempting to create "shared savings" — saving money for the government and itself. In mid-2013, Partners announced that in its first year in the program, it had generated about $14.4 million in savings to be split with the Medicare program. Partners has also been cutting similar deals with commercial payers.

"When we talk about population health management, we think about it holistically, not necessarily just in terms of the Medicare population," Partners CIO James Noga says. "We anticipate more and more payer contracts in which hospitals and healthcare systems will continue to take on additional risk."

That trend started before the passage of Obamacare, but "the ACA probably put it more in focus," Noga says. Despite the demands this regulatory push places on his organization, Noga says it's a push in the right direction. Being less reactive and doing a better job of following up on patients with chronic conditions is the industry's best chance of "bending the cost curve" while im-

proving the quality of care, he says.

Partners is betting that as private insurers see Medicare lowering costs with this approach, their interest in ACOs will intensify, Noga says. "For us, it's a strategy," he says.

The trend toward ACOs and population health management has driven Partners to retool. It's the impetus for a major Partners initiative to consolidate patient data onto one EHR, Epic, from the several it has at different hospitals. On the other hand, because Partners is only getting started on what will be a five-year rollout of the Epic software, it will still have to deal with a blended environment for some time to come. For example, Partners will continue to refine a patient portal developed internally, even though at least some elements of that portal will eventually be supplanted by Epic's MyChart.

"Our organization has been able to set up as an integrated delivery network, and that's just a blessing right now."

— David Lundahl, VP and regional CIO, Dean Health System

Nor is an EHR necessarily the be-all-and-end-all platform for population health management, Noga says. Caregivers will need analytics dashboards that help them identify individuals and group them into populations with common chronic conditions, such as diabetes, so they can devise strategies for better managing their health. Clinical decision support tools need to guide medical professionals toward delivering the best evidence-driven care. Primary care physicians need to get automated alerts when a patient in their care is admitted to the hospital or visits the emergency room, as well as follow-up reminders. Continuous monitoring of patients via devices in the home will become increasingly important.

"You can't buy, quote, a 'population health management tool,' because it isn't one tool. It isn't a module," Noga says. "You need many things to be able manage populations."

Sharp HealthCare CIO Spooner says he comes to the ACO model with experience in other forms of managed care, since California has long been a hotbed of activity with capitated payments for patient care. However, he discovered that ACOs, as implemented by Medicare, are significantly different. In particular, the government assigns each ACO a pool of patients whose health it is supposed to manage, but it doesn't limit Medicare recipients to getting care from providers in the ACO network, presumably for fear of limiting patient choice.

"There are more patients who are voters than there are providers, so we're outnumbered," Spooner says.

In a Medicare ACO, networks of providers are assigned patients to whom they have historically provided care, but it's up to the ACO to keep those patients coming back and to get them to proactively manage their own health. Online patient engagement is one of the most critical technologies here. It's a means of creating "stickiness" so that patients continue to work with a hospital for the same reason Amazon.com customers keep buying from that website. "You need to be the most attractive, engaging proposition in town," Spooner says.

Sharp created its own patient portal three to four years ago, allowing it to start building an online relationship with patients, although Spooner acknowledges "we're a long way from Amazon.com." Recognizing that commercial patient portal products have advanced significantly in the past few years, Spooner says Sharp will probably convert to one of them soon.

Care management or case management is

another essential technology Sharp is struggling to address more effectively, Spooner says. "It's like CRM for healthcare — you want to be tracking the patient in everything they're doing and be handing off the information more than just transferring medical records," he says. In complex cases such as cancer treatment, it's essential that strategies for follow-up care accompany the patient record, he says.

"Care coordination will ultimately become better."

— Shafiq Rab, CIO, Hackensack University Medical Center

IDC's Burghard says the biggest IT challenge is probably analytics. Most providers have been relying on their EHR platform vendor, rarely the best call, she says. "Those are all transactional systems, and their strength is not in the analytics," she says, creating an opportunity for vendors of niche population health analytics applications.

In many cases, ACOs are formed by networks of hospitals and providers that use several EHR systems. "Bringing all that data together in a meaningful way is a challenge both from a technological perspective and almost more so from a domain expertise point of view," Burghard says. The software alone can't do the analysis, and there aren't enough talented informaticists and biostatisticians to go around, she says.

The expectations for ACOs are also likely to be ratcheted up, Burghard says. "A lot of successes of the federal programs as well as the commercial programs is pretty low-hanging fruit — like keeping people out of the emergency room and reducing readmissions," she says. "Clinical improvement is the really tough nut to crack." In other words, the more worthwhile goal is detecting the best patterns of care, feeding them back to clinicians, and then achieving improvements in the practice of medicine.

Not everyone is eager to get started.

Robert Budman, chief medical information officer at Yuma Regional Medical Center, says an ACO could make a lot of sense in Yuma's southwestern Arizona area, given that there's "no other hospital for 50 or 60 miles in any direction" and that the community has a large Medicare population. However, he balks at the challenge of assembling all the physicians in the area into an organization with the capacity to provide comprehensive care for 5,000 or more Medicare patients (CMS's minimum threshold for participation).

"We have 100 projects to do, maybe more, and only money to do a handful, so we have to choose very wisely which ones we're going to do — and ACO is a huge one," Budman says. "It's a gargantuan undertaking, and it's got to be done right."

In other words, implementing an ACO is something his organization will want to do eventually, but it doesn't need to be among the pioneers.

New And Existing Networks

For other organizations, the ACO model isn't that big of a change. Integrated healthcare delivery networks such as Kaiser Permanente that both provide care and finance that care have arguably been operating as ACOs all along. Other health systems that offer their own insurance plans also have experience with the financial risk of the healthcare business.

"Our organization has been set up as an integrated delivery network, and that's just a blessing right now," says David Lundal, VP and regional CIO at Dean Health System in Madison, Wis. "We're at risk for about 40% of our

business, so if we manage care well, it's in our best interest to do that."

That doesn't mean Lundal has all the answers. Probably the most essential enabling technology is the electronic medical records system, Lundal says, and he feels confident in his organization's implementation of Epic. "We've got the EMR behind us, and that's the biggest thing we'll ever do," he says. "On the other hand, there was something relatively straightforward about implementing an EMR. It pushes you to do the biggest and hardest thing you've ever done over the course of five, six, seven years. This new stuff, there is not a road map — it's more creative and inventive."

When healthcare providers that aren't part of the same integrated delivery network form an ACO, one of their key challenges is to make independently chosen IT systems work together.

For example, addressing the goal of helping diabetics manage their disease better requires a strategy for analyzing data from the EMR, but also integrating other data sources, such as laboratory records. Population health management means analyzing the conditions that drive patients to the emergency room and strategizing to divert them to lower-cost care at their doctor's office, or via a video telemedicine consultation.

Lundal says one of his challenges is preventing the IT staff from becoming too bogged down in meeting regulatory requirements so they will have time for more innovative work — a sentiment reinforced last year at a meeting of InformationWeek Healthcare's CIO advisory board.

When healthcare providers that aren't part of the same integrated delivery network come together to form an ACO, one of their key challenges is to make IT systems that were chosen independently all work together. "I'm begging people not to have 75 different EMRs," says Shafiq Rab, CIO at Hackensack University Medical Center, which operates a regional ACO in New Jersey that recently reported achieving $10 million in shared savings for Medicare.

While it would be helpful to have one EMR standard, for now Rab is trying to steer participants toward four or five preferred vendors. "And if the EMR does not totally integrate, then it's time to choose another EMR," he adds. Another base requirement is that participating providers must connect to a health information exchange. "If they're not connected with an HIE, it's not going to work out," Rab says.

In addition, Hackensack University Medical Center hired a company called Team of Care Solutions, which provides active care coordination management, data integration, and business performance management predictive analytics to help the ACO function better. New technology is required because "care coordination is never something people have ever been paid for," says Alan Gilbert, co-founder and chief growth officer for Team of Care. It used to be that follow-up communications with patients was something doctors were supposed to do in their spare time, whereas an ACO should be able to recognize that time as just as valuable as time spent on office visits, Gilbert says.

A few years from now, ACOs may be called by another name, but the basic idea of changing how healthcare services are valued and paid for will remain, Rab predicts. Once Medicare demonstrates that it can achieve real savings with this model, private payers will follow. "Care coordination will ultimately become better," he says. "As reimbursements are more guided by preventative care, this will have its own legs."

David F. Carr is editor of InformationWeek Healthcare. Share a digital version of this story and read others here. Write to him at david.carr@ubm.com.

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