# The Landscape of Accountable Care and Connected Health

Results from 2014 National Survey of Accountable Care Organizations





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### **EXECUTIVE SUMMARY**

### **Overview**

Recent reforms are driving a sea change toward a value-based, coordinated care paradigm that incentivizes health providers based on the quality and health of a population, not quantity of care delivered across the continuum. New payment and delivery models such as accountable care organizations (ACOs) are being implemented across the country to improve the value of care. In shifting shared risk and responsibility from payers to health providers directly, ACOs strive to achieve the Triple Aim of better care, better outcomes and better costs. Since the Centers for Medicare & Medicaid Services (CMS) initially rolled out ACO programs in 2011, a wide range of ACO models have proliferated in Medicare and Medicaid programs, as well as among commercial payers and employers. While they vary in approach, size and complexity, ACOs are fundamentally redesigning the healthcare delivery system.

Because ACO partnerships often integrate providers, specialists and systems across disparate settings into a unified network, they must effectively coordinate care to manage health and risk both at an individual and population level. A robust health information technology (health IT) infrastructure allows ACOs to derive actionable value out of information collected from various data sources to build a complete, secure and up-to-date record of a patient's health and medical history that is easily accessible, shared, and updated over time. ACOs also often depend upon clinical, claims, financial, and administrative data to continuously measure, monitor, analyze, and improve clinician performance and patient outcomes. At individual patient levels, health IT can enable care providers within an ACO to work in concert to capture and act upon data as a patient consults primary care physicians or specialists, receives tests and treatments, fills prescriptions, and returns home for post-discharge monitoring. By combining and analyzing data, ACOs can measure and compare their internal metrics with nationally recognized best practices, standards, and evidencebased guidelines to improve the guality of care across the continuum. At the aggregate level, data can be used for clinical decision support, risk stratification, and predictive modeling to support analytic efforts targeting quality, safety, efficiency, cost, and utilization of care.

The field of accountable care is still relatively nascent, and ACOs are taking a variety of approaches to developing, deploying and expanding health IT capabilities. It is therefore important to understand the health IT assets that are needed to improve coordination and convenience. In July and August of 2014, eHealth Initiative (eHI) and Premier, Inc. fielded an online survey of ACOs to determine the current capabilities and challenges of health IT implementation across the country. Responses were received from 62 organizations, including members of Premier's Partnership for Care Transformation (PACT<sup>TM</sup>) Population Health Collaborative.



### **Key Findings**

The following findings were drawn after careful review of the survey results.

ACOs report diverse health IT capabilities, the core building blocks of which revolve around population health management and billing. The majority of surveyed ACOs have a health IT infrastructure that can support quality measurement, population health management, and physician payment and contract adjudication. Core health IT components for ACO providers include electronic health records (EHRs), disease registries, data warehouses, and clinical decision support systems (CDSS). In addition, most surveyed ACOs reported advanced deployment of patient-facing tools that can improve efficiency and reduce administrative bottlenecks such as tethered patient web portals, e-prescribing capabilities or patient reminders.

However, more advanced capabilities to support patient engagement remain in their infancy. Few organizations use patient-facing tools that could increase access to care, nor are they well equipped to use secure messaging, referral management tools, or telemedicine. Even fewer offer patients self-management tools such as remote monitoring devices, untethered personal health records (PHR), or smartphone apps. Given that many of the newer ACOs are forming in rural and/or underserved areas, this is a concerning finding that organizations may be unable to leverage health IT to effectively manage populations in remote geographic areas.

Furthermore, few of the surveyed ACOs report use of revenue cycle management or a master patient index (MPI). Without these components in place, most ACOs report that their infrastructure is unable to effectively support risk management.

**Robust analytic capabilities are essential, but data access remains a prohibitive barrier.** ACOs primarily collect electronic clinical data, post-adjudicated claims-data, and pre-adjudicated administrative, billing or financial data to support operations. However, most ACOs have yet to incorporate information from a state or disease registry, health information exchange or remote monitoring devices and sensors. ACOs are also unlikely to collected patient-reported data or unstructured textual data.

According to survey respondents, a key reason why these capabilities have yet to mature is because access to data remains a significant challenge. Every respondent reported problems accessing data from external organizations or networks. Compounding the challenge is the fact that a large percent of ACOs are also facing significant obstacles in integrating and blending data from disparate sources. Even when ACOs are able to access information from internal or external sources, they often encounter problems with data quality and liquidity – barriers that become more acute as ACOs add more platforms or build a more expansive network of medical settings.



**Health IT has been associated with targeted improvements in performance and quality of care.** Survey findings reflect recent academic reports and peerreviewed publications indicating modest improvements in health outcomes, quality of care, performance, cost, and efficiency associated with the use of health IT. At least half to two-thirds of ACOs reported improvements in health outcomes, chronic disease management, preventive screenings and vaccinations, and clinical quality improvement.

Compared with organizations surveyed in 2013, the most dramatic improvements were in the areas of reduced hospital admissions, readmissions and Emergency Room (ER) visits. Because the above areas are heavily tied to a number of payment and reimbursement structures, ACOs may be focusing health IT capabilities initially around financial incentives. However, accountable care objectives are often tied to indicators such as patient safety, cost containment, efficiency, and patient satisfaction – none of which improved among the majority of ACOs.

ACOs have been unable to effectively scale health IT to address needs and challenges. Compared with the 2013 survey cohort of ACOs, the cost and return-on-investment of health IT has become a crippling concern for organizations today, which may indicate a slow-down in IT spending over the longer term and inhibit provider efforts to scale systems to additional care settings and platforms. Indeed, most ACOs have not made significant improvements in capabilities compared with the 2013 cohort. ACOs have become increasingly challenged by the integration of technology into workflow patterns, and report difficulties hiring qualified health IT staff, which also may contribute to scaling and expanding.

Despite the investments made in health IT infrastructure, ACOs continue to report significant challenges to effectively using technology, chiefly driven by today's lack of interoperability. Even when ACOs have successfully adopted and/or merged health IT systems, they face a number of barriers to effectively leverage data and analytics to derive value out of their investments due to the pervasive issues of data access, quality, liquidity, and integration from disparate sources.

### BACKGROUND

The health IT infrastructure of ACOs is often a reflection of the capabilities of the participating stakeholders within the network. Many hospitals and physician groups across the country have adopted and upgraded their electronic health record systems (EHRs) to qualify for federal meaningful use incentives. Because ACOs are often administered by these stakeholders, they typically tend to have an EHR system with functionalities that mirror requirements of Stages 1 and 2 of meaningful use. However, in many cases, these basic EHR systems are not sufficient for accountable care operations, nor can they adequately support the needs of ACO networks as they expand to integrate additional specialists, retail pharmacies and laboratories, behavioral health, and post-acute care.

Achieving delivery system transformation will require a phased approach to care coordination and clinical integration through the following levels:

• **Transaction** — IT supporting individual providers in delivering care and measuring outcomes, including EHR systems that collect and report clinical measures.

• **Interaction** — Basic care coordination capabilities with straightforward populationbased metrics, such as clinical decision support systems, care management technologies, disease registries, and small-scale population analytics.

• **Integration**— Care coordination capabilities and health status measurement using outcome measurement and reporting, virtual care team coordination, and individual patient activation and monitoring systems.

• **Collaboration** — Seamless care coordination with demonstrable improvement in population health status using systems that facilitates workflow across sites of care and virtual provider collaboration.

• **Transformation** — The ACO core goals of better health care, better health, and reduced costs of care are achieved for all covered patients using advanced population analytics, continuous process improvement systems, as well as ongoing risk and financial management.





### **OVERVIEW OF SURVEY**

#### **Survey Respondents**

Of the 62 ACOs that responded to the survey, the majority had been operating for at least 18 months. Thirty-five percent were in mature stages of operation (more than two years), 20 percent were in advanced stages of operation (between 18 and 24 months) and 20 percent were in intermediate stages of operation (12 to 18 months).

### **Workforce and Patient Mix**

Nearly all ACOs were of a medium to large size with between 101-500 physicians (39%) or more than 500 (41%) physicians. ACOs are largely comprised of primary care clinics and practices (90%), specialists (84%), acute care hospitals (57%), health systems (53%) and hospitals (51%). To date, few have incorporated long-term care (22%), skilled nursing facilities (29%), rehabilitation (31%) or home health (37%). Compared to a 2013 survey conducted by eHealth Initiative of a different sample of ACOs, behavioral healthcare (43%) and palliative/hospice care (41%) have both become more common services. Surveyed ACOs primarily serve between 10,000 to 100,000 patients, the majority of which are on Medicare. ACOs with a patient population under 10,000 do not generally provide services beyond basic primary and acute care. The figure below illustrates the number of lives covered and the participating populations.



### Figure 1: Patient Mix of Surveyed ACOs



### **Funding Models**

Surveyed ACOs are primarily funded and administered by a health system (33%), medical groups (16%), or independent practice associations (IPA) (12%). Other stakeholders include a physician-hospital organization (10%), independent ACO entity (8%), or hospital (6%).

### **Contract Models**

Many organizations pursuing accountable care are already participating in alternative payment mechanisms. At the provider level, despite numerous variants, most providers pursuing accountable care are already participating in one of the following four payment alternatives:

- 1. **Fee-for-Service Plus Bonus:** Under this model, payers continue to pay ACOs on a fee-for-service (FFS) basis for all services, but add in a year-end bonus if spending is lower than a benchmark level. In our survey, 45 percent of respondents reported this type of contracting arrangement.
- 2. **Bundled Payment:** Retrospective bundled payment, pay participants under the existing fee-for-service (FFS) system, but at a negotiated discount. At the end of the episode, the total payments are compared to the target price, and providers are able to share in any resulting savings. In a prospective model, the total discounted payment is made in advance, and providers are paid for services out of the bundle. Twelve percent of surveyed ACOs have a bundled payment contracting model in place.
- 3. **Shared Savings:** Under shared savings, if the actual cost of care is less than a projected cost, the provider receives a percentage of the savings, subject to meeting quality and patient experience benchmarks. Shared savings models generally take two forms one where there is no downside risk for failing to achieve cost targets, and one where the provider agrees to pay back spending above projected costs. Upside shared savings is the most popular among the surveyed ACOs, with 84 percent operating under this contracting model. Twenty-four percent of the survey respondents reported downside shared savings arrangements.
- 4. Capitation: Capitated payments typically are paid periodically (e.g., monthly) based on projected spending, but may be augmented based on a quality and/or patient experience measures. Capitation can cover all medical costs or specified components such as physician services or inpatient hospital care. Only 16 percent of ACOs responding to the survey reported a capitated contracting model.





## **KEY FINDINGS**

### 1. ACOs report diverse health IT infrastructure capabilities, the core building blocks of which revolve around population health management and billing.

### **Health IT Capabilities: Providers**

The majority of surveyed ACOs have a health IT infrastructure that can support quality measurement, population health management, and physician payment and contract adjudication. As shown below in Figure 2, core health IT components for ACO providers include an EHR (86%), disease registry (74%), data warehouse (68%) and clinical decision support system (58%). However, only 28 percent of ACOs report use of revenue cycle management or a master patient index (MPI), suggesting that many organizations may not be well-equipped to manage patient populations and lower costs. Without these components in place, most ACOs also report that their infrastructure is unable to effectively support patient engagement and risk management.

## Figure 2: What health IT components can providers in your organization use to support accountable care activities?



The above figure also suggests that ACO capabilities for distance-based medicine have yet to fully mature, with few organizations able to use secure messaging (38%), referral management tools (36%), phone-based telemedicine (34%) or video-based telemedicine (26%). Given that many of the newer ACOs are forming in rural and/or underserved areas, it is concerning that ACOs may be unable to leverage health IT to



effectively manage populations in remote geographic areas - particularly if, as will be discussed below, data exchange is reported by less than half of survey respondents.

The organizational leadership administering an ACO may significantly impact approaches to provider-facing technology. While 66 percent of providers at hospital-administered ACOs use phone- or video-based telemedicine, less than half of providers at ACOs administered by other stakeholders use the technology. However, hospital-administered ACOs are less likely to have a data warehouse (33%), disease registry (33%) or MPI (0%). ACOs administered by a medical group are significantly less likely to have CDSS (28%), while only 17 percent of IPA-administered ACOs use an MPI. ACOs administered by health systems are the only respondents that use a Record Locator Service (RLS) (11%). Generally speaking, small to medium-sized ACOs (defined as less than 100 physicians on staff) do not have a health IT infrastructure beyond the four building blocks of a data warehouse, disease registry, EHR, and health information exchange. However, capabilities do not change significantly among larger ACOs with more than 100 physicians. Less than half of larger ACOs feature components such as a CDSS, RLS, revenue cycle management system, telemedicine, or referral management system.

### **Health IT Capabilities: Patients**

Patients served by an ACO can generally use basic internet-based tools to support their care; however, few organizations have yet to incorporate more advanced mobile capabilities. The majority of ACOs have deployed patient-facing tools that are geared toward improving efficiency and reducing administrative bottlenecks, such as a tethered patient web portal (94%), ePrescribing (70%) or patient notifications and reminders (61%).



### Figure 3: What consumer-facing health IT tools can ACO patients use?



Few ACOs to date report patient-facing tools that could increase access to care, such as self-service scheduling (33%), phone-based telemedicine (28%) or video-based telemedicine (24%). ACOs are even less likely to offer patients self-management tools such as remote monitoring devices (26%), untethered personal health record (17%), or smartphone apps (15%). However, smaller (less than 50) and larger (more than 500) ACOs tend to be more innovative and experimental in adopting personal health records and mobile devices.

## 2. Robust analytic capabilities are essential, but data access remains a prohibitive barrier.

### **Common Data Sources**

ACOs primarily collect electronic clinical data (95%); post-adjudicated claims-data (95%); and pre-adjudicated administrative, billing or financial data (63%) to support accountable care operations. However, most ACOs have yet to incorporate information from a state or disease registry (37%), health information exchange (22%) or remote monitoring devices and sensors (22%). ACOs are also unlikely to collected patient-reported data (34%) or unstructured textual data (29%).

#### **Data Access**

While the diversity of health IT systems and available data sources vary across organizations, the majority of surveyed ACOs pull information from only a handful of platforms, as shown to the right. As one might intuit, larger and more mature ACOs are likely to collect data from various platforms and sources. However, as ACOs pull data from more sources, they also report lower abilities to leverage their health IT infrastructure to support care coordination, patient engagement, physician payment and contract adjudication, population health management and quality measurement. Without seamless or frictionless access to information, ACOs report significant challenges with integrating technology (88%) and analytics (83%) into workflow.









While only half of ACOs report that access to data organization within their or network is а challenge, access to data from external organizations or networks is challenging for 100 percent of survey respondents. Compounding the challenge of accessing and sharing data is the fact that 88 percent of ACOs are also facing significant obstacles in integrating and blending data from disparate sources - a barrier that becomes more acute as ACOs add more platforms or build a more

Access to data from external organizations or networks is a key challenge for <u>every</u> ACO

expansive network of medical settings. Indeed, as ACOs collect data from more sources, they also report increased concerns about interoperability and data management. Interoperability is a significant challenge for 95 percent of organizations to using health IT, and is most likely limiting the abilities of ACOs to exchange data.

#### **Health Information Exchange Capabilities**

Data exchange is critical to accessing complete patient records and effectively coordinating care – but to date, few ACOs participate in a health information exchange (HIE, let alone perceive seamless HIE to be strategically important for achieving organizational goals. Figure 5 on the following page illustrates current ACO participation and/or plans to participate in an HIE, neither of which have changed significantly compared to organizations surveyed in 2013.

The majority of ACOs have yet to fully leverage health information exchange for their operations. Nearly half of ACOs have an infrastructure that has capabilities required for HIE (44%), but only a marginal portion have adopted a master patient index (28%) or record locator service (6%) to better facilitate information exchange. In comparison with the other survey respondents, larger ACOs are more likely to participate or plan to participate in private or hybrid HIEs. As ACOs enter advanced to mature stages of operation, they also begin participating more actively in HIEs.







**Figure 5: Please indicate if your organization participates in a Health Information Exchange (HIE).** 

■ No ■ No, but plan to in future ■ Yes

When broken down by the stakeholder administering the ACO, the differences are more stark. Only 14 percent of ACOs administered by medical groups use an HIE compared to more than half of other ACOs. ACOs administered by an IPA appear to be better equipped to participate in a community-based HIE (75 percent) or private/enterprise HIE (60 percent) than ACOs led by other stakeholder groups. While some ACOs use a hybrid HIE (10%), private/enterprise HIE (10%) or community-based HIE (4%) to coordinate care or monitor network leakage, the vast majority do not (76%). As new patient populations continue to enter the healthcare system during the second year of healthcare insurance exchanges (HIX), it remains to be seen whether ACOs will increase exchange activities to better monitor populations.

### Analytic Capabilities

Eighty-eight percent of ACOs agree that robust analytics are required to be successful. However, strategic planning is required by most organizations before they are able to effectively collect and analyze the growing volume of available electronic information to achieve the Triple Aim. Even when ACOs are able to access information from internal or external sources, they often encounter problems with data quality (74%) and liquidity (76%). Additionally, more than 81 percent of ACOs agree that quality measures need to be more aligned for their organizations to be efficient. Due to the fragmented measures required by various reimbursement models in Medicare and the private sector, ACOs are further handicapped by the need to measure performance



with multiple metrics. The integration of analytics into practice has proven to be a significant challenge for 73 percent of organizations, which may explain why 80 percent of ACOs also report low levels of return-on-investment (ROI).

## **3.** Health IT has been associated with targeted improvements in performance and quality of care

Survey findings reflect recent academic reports and peer-reviewed publications that indicate modest improvements in health outcomes, quality of care, performance, cost and efficiency associated with the use of health IT. As can be seen in the table below, at least half to two-thirds of ACOs reported improvements in health outcomes, chronic disease management, preventive screenings and vaccinations, and clinical quality improvement. It is encouraging to see health IT contributing to improvements of varying degrees to some of the most critical challenges in healthcare today that are presented by the prevention, treatment and management of chronic conditions.

## Table 1: Please indicate how health IT has contributed to the following areasat your ACO

Performance Areas	Improved	Worsened
Clinical quality improvement	66%	7%
Preventive screenings/vaccinations	63%	12%
Chronic disease management	59%	10%
Health outcomes	55%	6%
Reduction of hospital readmissions	51%	17%
Reduction of ER visits	49%	27%
Reduction of hospital admissions	44%	17%
Patient safety	39%	20%
Cost savings	39%	22%
Reduction of healthcare utilization	37%	27%
Efficiency	32%	20%
Provider satisfaction	30%	22%
Patient satisfaction	29%	35%



Compared with organizations surveyed in 2013, the 2014 cohort of ACOs only showed reported improvements (15-20%) in the reduction of hospital admissions, hospital readmissions and ER visits. Because these areas are heavily tied to a number of payment and reimbursement structures, ACOs may be focusing health IT capabilities initially around financial incentives. However, accountable care objectives are often tied to indicators such as patient safety, cost containment, efficiency and patient satisfaction – none of which improved among the majority of ACOs. Provider satisfaction is notably lower among smaller ACOs under 50 physicians, suggesting that larger organizations may have a better culture or training system in place. ACOs administered by hospitals were unable to leverage technology to achieve cost savings or reductions in healthcare utilization.

### 4. ACOs have been unable to effectively scale health IT to address needs and challenges. Most have not made significant improvements in capabilities since 2013.

Compared with the 2013 survey cohort of ACOs, the cost and return-on-investment of health IT has become a crippling concern for organizations today, growing from 14 percent to more than 90 percent of ACOs. ACOs have also become increasingly challenged by the integration of technology into workflow patterns, growing from 50 percent to 90 percent of organizations over the past year. Similarly, the percentage of organizations with difficulties hiring health IT staff doubled from 30 percent to 66 percent. Today, less than half of ACOs have sufficiently trained staff to collect, process and analyze data, as illustrated in Figure 6 below.

## **Figure 6: Does your ACO organization have sufficient trained staff to collect, process, and analyze data?**





As ACOs operate over time, they face unique health IT challenges that may require staff with different core competencies as they move from initial adoption, deployment, implementation, and ongoing development and management of technology solutions. While 100 percent of early-stage ACOs report having enough staff to collect and analyze data, the rate quickly drops off among ACOs in intermediate (27%) and advanced stages (33%), before increasing back to 66 percent of mature organizations that have been operating for at least two years. While 100 percent of ACOs administered by a hospital reported being understaffed, other organizations administered by a health system (60%), IPA (80%) or medical group (80%) are adequately staffed. However, smaller ACOs that are staffed by less than 50 physicians report significantly greater challenges with hiring.

### DISCUSSION

The adoption and deployment of health IT should not be treated with a plug-and-play panacea mindset, but rather a phased, structured approach over time with an emphasis on interoperability and integration.

### <u>Tipping Point</u>

Of the organizations surveyed, larger ACOs have more technological capabilities and are better staffed and equipped to leverage them. Once ACOs reach 18 months of operation, they report substantially more advanced capabilities, data used for analytics and performance improvements associated with health IT – but also more acute challenges.

### Challenges on the Horizon

Despite the investments made in health IT infrastructure, ACOs continue to report significant challenges to effectively using technology. In descending order of importance, they are:

- 1. Cost (95%)
- 2. Interoperability (95%)
- 3. Lack of funding or ROI (90%)
- 4. Workflow integration (88%)
- 5. Lack of provider engagement (73%)
- 6. Lack of trained staff (69%)
- 7. Lack of consensus on quality benchmarks and measures (67%)
- 8. Privacy and confidentiality (43%)

Even when ACOs have successfully adopted and/or merged health IT systems, they also face a number of barriers to actually leveraging data and analytics to derive value out of their investments. In descending order of importance, these obstacles are:





- 1. Access to external data (100%)
- 2. Integration and blending of disparate data (88%)
- 3. Workflow integration (83%)
- 4. Lack of funding or ROI (80%)
- 5. Data liquidity (76%)
- 6. Data quality (74%)
- 7. Applying analytics into practice (73%)
- 8. Lack of trained staff (66%)

### **Public Policy Implications**

Widespread adoption of health IT was intended to enable integrated, patient-centered care that enhances patient safety, care coordination and health system efficiency. Although health IT is a core building block to enabling the effectiveness of ACOs, the survey shows that adoption of more advanced IT components has begun to stall out, chiefly due to prohibitive costs, poor systems interoperability, inability to access data from disparate external sources and a lack of skilled employees to mine and analyze data.

Much of the problem lies in the fact that today most health IT systems are "locked" within proprietary silos, which hinders their ability to connect and exchange information with other systems, medical devices and sensors along the care continuum. A recent Health Affairs article noted that today's health IT systems operate less like ATM cards - which would allow providers to access patient information anytime, anywhere - and more like frequent flyer club cards designed to preserve brand loyalty. In order to build bridges that connect disparate data sets, care providers are forced to either pay their original system vendors thousands of dollars to custom code links so they can "talk" to other health IT assets, or do it themselves at an enormous expense, both in raw dollars and manpower. In fact, research suggests that efforts to unlock closed systems results in enormous added expense, costing providers \$8 billion annually in the United States.<sup>1</sup> This added expense is likely one of the core reasons why survey respondents reported high levels of dissatisfaction with the cost and ROI of health IT.

In April, 2014, the JASON Advisory Panel released a report which found that the current lack of interoperability among data sources for health IT is a major impediment to the exchange of health information and a robust health data infrastructure that can enable increased care quality and efficiency. <sup>2</sup> This survey

<sup>&</sup>lt;sup>1</sup> http://www.healthit.gov/policy-researchers-implementers/health-it-and-patient-safety.

<sup>&</sup>lt;sup>2</sup> JASON. "A Robust Health Data Infrastructure," prepared for the Agency for Health Care Research and Quality, AHRQ publication number 14-0041-EF, http://healthit.gov/sites/default/files/ptp13-700hhs\_white.pdf.



further reaffirms this finding, with ACOs reporting widespread issues with data access, liquidity and interoperability between systems.

According to both JASON and the President's Council of Advisors on Science and Technology, the most important step in reducing unnecessary fragmentation of healthcare data and improving the accessibility and usability of healthcare data for consumers, payers and providers is to require the utilization of new innovative technologies such as open and secure Application Programming Interfaces (APIs). An API is a set of functions and procedures used by computer programs to communicate with one another. Requiring open APIs as a foundational and integral standard for healthcare data would reverse the current legacy state of locked systems and enable bi-directional and real time exchange of health data currently residing in disparate health IT systems. Enabling interoperability in healthcare in this way would help providers reduce costs and improve patient care, quality and safety, thus clearing away many of the barriers reported by survey respondents. To advance this work, it may be necessary for the Office of the National Coordinator for Health Information Technology (ONC) to lead, through government action, by requiring open APIs for data elements in health IT systems.

As ACOs expand and mature to cover larger patient populations across disparate settings, they require better alignment of data measurement, collection, reporting, and analytic efforts to improve quality of care, reduce associated costs, and manage patients across the healthcare system. While ACOs continue to predominantly rely upon clinical, pre-adjudicated and post-adjudicated forms of data, the need for standards and quality will only grow in importance as organizations begin to analyze patient-reported measures and unstructured textual data. Similarly, ACOs should be mindful of the changing resources that are required as organizations grow and mature to perform more advanced activities. Staff must be able to leverage health IT to achieve greater improvements in healthcare safety, efficiency, cost containment and engagement, and organizations must develop effective strategies to apply technology to risk management.

### CONCLUSION

The success of ACOs would not have been possible were it not for technology. In only a few short years, the adoption of EHRs and HIT tools has had a profound impact on healthcare organizations. Today, ACOs are integrating electronic health data from disparate systems and settings into workflows to drive actionable insights and achieve the Triple Aim. However, to successfully use analytics, leaders must navigate difficult barriers such as interoperability, high costs and analytically oriented staff. Results from the 2014 ACO survey suggest that although many organizations are well on their



way to advanced stages of operation and adequately achieving accountable care goals, ACO leadership should develop a scalable – and sustainable - long-term health IT plan that targets specific organizational objectives, problems and challenges.



## **APPENDIX: LIST OF 2014 SURVEY RESPONDENTS**

On behalf of eHealth Initiative and Premier Inc., we would like to thank the anonymous respondents and participating organizations below who completed the survey:

**AmpliPHY Physician Services** Aurora Health Care **BayCare Physician Partners** Baylor Scott & White Quality Alliance Beacon Health Partners, LLP Cape Cod Health Network ACO Caribbean Accountable Care, Inc. Carilion Clinic Caring Hand to Mouth CaroMont Health Catholic Heatlh Initiatives Catholic Medical Partners CHESS CHSI Coastal Carolina Quality Care, Inc. Collaborative Health ACO DHMC **Digital Health Space** Eastern Oregon CCO Franciscan Alliance Genesys PHO LLC HackensackAlliance ACO Hennepin County ISHN/MSHA Kettering Health Network **Keystone ACO** 

Mercy Health Meridian Mid Roque eHealth Services **MissionPoint Health Partners** MNT Mountain States Health Alliance NH Accountable Care Partners NOMS Healthcare Ochsner Health System Physician Health Partners **ProHEALTH Accountable Care Medical** Group **ProHealth Physicians** Rainier Health Network (Franciscan Northwest Physicians Health Network) Saint Vincent Southcoast Health Summa ACO **Texas Physicians ACO** The Polyclinic TP-ACO, L.L.C. University Hospitals Vidant Health Waco Orthopedic Clinic WESTMED Medical Group