Accountable Care and Health IT Hearing
HITPC Accountable Care Workgroup
Crystal City Marriott
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Prepared Comments
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Panel 1

Overview of our Organization

Coastal Carolina Health Care, PA is a 50 provider multispecialty medical group based in rural Eastern North Carolina. The group's specialties include Internal Medicine, Family Practice, Hematology, Oncology, Gastroenterology, Cardiology, Pulmonary Diseases, Critical Care, Endocrinology, Rheumatology, and Neurology. Approximately 60% of these providers specialize in adult primary care. Our organization was selected by CMS in its first round in April 2012 as an Advance Payment Model ACO. The medical practice serves as the ACO's sole participant and it derives approximately 50% of its revenue from its approximately 11,000 attributed Medicare beneficiaries.

Written Response to Questions

1. Coastal Carolina Health Care (CCHC) and its ACO have taken a number of steps to meet cost and quality goals.

- Established a quality control and improvement committee to create and implement targeted programs.
- Implemented an integrated point-of-care computer "dashboard" which identifies gaps in care so that the clinical staff can work as a team to help close them at each point of contact.
- Developed monthly quality reports detailing measures for each provider and practice. The data includes all patients and is un-blinded. The measures used match those specified by the MSSP.
- Included these measures as a component of the proposed savings distribution plan and communicated this to the staff.
- Added clinical staff at the point of care to assist providers in meeting these quality measures. The providers requested the additional staff were responsible for the cost.
- Hired care managers and a supervisor to help manage the sickest and highest risk patients.
- Established a 24/7 Nurse Triage Line with authority to grant next day appointments when deemed necessary.
- Increased hours and capabilities at its urgent care center.
- Increased awareness and marketing of its urgent care center to attributed Medicare beneficiaries.
- Had medical director review and monitor all local ED visits and hospitalizations looking for opportunities and reporting these to the clinical staff for education and outreach.
- Developed monthly internal reports to track ED and hospital utilization.

- Purchased web based software to aggregate claims data and help identify opportunities and trends.
- Created awareness of patient alternatives to ambulance transportation.

Information technology is vital to the implementation of many if not most of these strategies.

2. One of the main challenges we have encountered is that the systems are still being developed. We have had to spend a lot of time educating ourselves and technology partners on what we need so that they can provide us with more valuable solutions. The programs we utilize are very helpful and continue to improve.

3. There seem to be are many solution providers available, but from what I have seen better tools are needed to compare and identify variation in costs between populations to help pinpoint areas where waste can be eliminated.

4. While we are working with community resources to better coordinate care, neither we nor these community providers are using a health information exchange. We utilize our EHR as the central repository and make this data available to our patients via a web based portal and other community providers by secure view only access. While this data has been available on our system for some time, it was not fully appreciated or used until we hired a nurse navigator and placed her in the ED to print the data for the providers and assist with the care transition.

5. Health IT tools have been vital in supporting our population health management strategies. In order for processes to be improved, they must be measured and incented. The MSSP incentives create the business case needed to support the clinical need and our experience shows that this works.

6. I am not certain certification of population health management applications would add much as the technical specifications are a continuously evolving based on the latest evidence. I believe periodic CMS audits of the quality data are sufficient to keep company's offerings up to date.

7. There are a number of challenges MSSP ACO's face with the claims data they are given. The main issue we have encountered is the completeness of the data provided. Complete data is needed for a number of purposes including: (1) Accurate profiling of provider practice patterns, (2) Implementation of reliable physician incentive programs, and (3) Ability to determine detail changes in utilization between periods. In sum, a complete data set will enhance accountability and increase engagement and performance. Patient confidentiality can be protected by removing identifiable data and prohibiting the linking of these specific records to other clinical data.

8. In our ACO the medical practice's electronic health record serves as the central repository for data; therefore, we strive to keep it both complete and current. To accomplish this we spend time re-entering data (laboratory results, problems, medications, history, etc.) we receive from outside groups and outside groups spend time reentering data we send to them. This process could be enhanced if EHRs could send and accept this discrete data. Any policies designed to enhance this transfer (i.e. designating standard

fields and requiring this functionality.) would be helpful in supporting ACO's continuity of care, population health management, and clinical decision support activities.

9. The cost of our EHR was funded by our medical group but we would not have been able to afford it based on the revenue we receive from evaluation and management services alone. We spent years developing our systems and investing in the people necessary to operate, upgrade, train, and support them. Our group's development of advanced reporting, population health management, and care coordination would not have been possible without the advance payments supplied by CMMI. These payments have allowed us to move to the next level and measurably impact key clinical measures. ACO's need to develop institutional knowledge on clinical quality reporting and improvement initiatives and I believe separate payments are required to support and achieve these goals. If we can spend 12% more for patients enrolled in Medicare Advantage plans than we do for traditional fee for service, then we should be able to spend an additional 1.0-2.0% investing in the necessary infrastructure to operate an ACO.

10. I believe the current incentives in the MSSP are sufficient to promote adoption and effective use of health IT and information exchange between ACO participants.

11. CMMI could support development of more advanced HIT functionality and ACO development by expanding the advance payment model to non-rural physician organizations with significant primary-care operations that otherwise would not have the necessary funding (i.e. non-hospital based entities).