

Testimony to ONC Care Coordination Workgroup
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Good Morning,

Thank you for the opportunity to discuss this important issue of Care Coordination and Meaningful Use. I am a practicing internist, and for several years have been engaged in developing, building, operating, and evaluating radically new models of primary care delivery to improve patient and physician experience, clinical outcomes, and affordability of health care.

Since early 2007, I have been working with AtlantiCare, a large integrated delivery system and the HEREIU Local 54 Fund, a Taft Hartley Trust that provides health care benefits to about 25,000 largely low wage hotel and casino workers and their families to build and operate a de novo medical home practice for their sickest patients in Atlantic City, NJ. This practice, called the Special Care Center, or SCC, was designed from the ground up to improve care and lower costs for the 10% of patients who have multiple chronic conditions, are responsible for up to 2/3 of all health care spending, and are the most poorly served by the current fragmented, reactive non system of care in the US.

The practice combines several innovative features to better serve this population, including:

- Use of language and culture concordant community health workers as personal health coaches to help engage patients in their care
- Extensive use of information therapy, group visits, email, and phone contact with patients, and home visits as needed
- Proactive reaching out to patients not in good control or after any change in therapy
- Guaranteed same day appointments and 24/7 phone access to doctors
- Integrated mental health and nutrition services
- Close coordination with a co-located pharmacy
- Co-management of inpatient care with a hospitalist group, and specialty care for some high volume specialists such as cardiology
- Daily huddles with the entire care team and time set aside each week to improve our processes

Instead of the usual fee for service billing, we are paid essentially a primary care capitation rate that is double the revenue per patient for a typical practice. The proposition is that for this sick group of patients we can more than make up for this through reduced ER, testing, and hospitalization costs. We have been in operation for 3 years now, and have over 1200 active patients enrolled. We already have data that we are dramatically improving patient and physician experience, improving outcomes, and lowering total cost of care.

The SCC is clearly not a typical practice, but one designed from the ground up to do a much better job than typical ones in coordinating care for patients with complex conditions, and hopefully represents where we want practices to evolve in the future. I would like today to talk about the challenges we have faced using current Healthcare IT systems to mediate our sort of intensive, practice based care coordination, and what this suggests for the next stages of Meaningful Use requirements.

There are many ways in which we need our IT systems to help us coordinate care, including:

- Reconciling medications between different doctors and care settings
- Tracking lab and other results ordered by different physician and performed in different places
- Communicating diagnoses, events, and new treatment plans between different settings and physicians
- Mediating care plans between different disciplines within the care team such as psychologists, nutritionists, case managers, health coaches, and physicians
- Allowing patients and their caregivers to view and interact with their record to play a role in understanding and coordinating their own care as they wish

Unfortunately even the best of the current off the shelf systems available to small practices like ourselves do an awful job of doing any of these. They are designed fundamentally as tools for doctors to document and code for visits within their own practice and generally do not allow for the sort of care coordination between different team members across different settings.

Let me give you some specific examples:

- Our medication lists frequently get corrupted when patients go see other providers- of course if they do not use our EHR, we have no record of their med changes, but even if they do, the way the system is designed, one doctor can inadvertently erase the medications prescribed by another
- The templates and documentation structures are very physician centric, and other professional such as social workers and health coaches are forced to use our formats- eg history of present illness, past history, review of systems, etc to document their notes
- If two users are in the chart simultaneously, as is often the case in our team based practice, their entries can cancel each other's out in unpredictable ways
- Despite having a large corporate health system IT department working on the issue for over 2 years, we have yet to get any of our lab values entered into our Electronic health record as data- largely because it could not match patients between systems, so instead they come in as static pdf files via the fax machine

So what would I like to see in terms of new system designs and potential Meaningful Use requirements to help us care for our patients in our new model of care?

- Systems that allow multiple disciplines to document in the same record, but in formats that are appropriate to the care they deliver

- Easy and unfettered data flow between labs, pharmacies, other doctors, and hospitals to give me a single place to see all current data about my patients, regardless of where they have been seen
- The ability of patients to view their entire record- including notes, labs, and results, and push their own data into the record including how they are feeling, and biometrics such as blood pressure and glucose readings
- Real time analytics to flag me or my health coaches when something is awry- such as my patient showed up in an ER or hospital, has a lab out of range, high blood sugar at home, or did not pick up their prescription within a certain range of time
- Dashboards to track how I and each member of my team is doing in terms of quality and utilization metrics for the patients they are caring for

Of course a pre-requisite for all this are different payment, staffing, and process models as we have been able to implement in Atlantic City. But assuming this is the way we have to evolve, we will then need improved IT systems such as I have described to help us truly deliver better, cheaper care for our patients.

Thank you.