Care Coordination Task Force

HIMSS North America

Care Coordination and IT Adoption Incentives: Early Gains and Lessons Learned

Introduction

The past 5 years have seen continued increases in physician practice adoption of health information technology (IT) in response to financial incentives provided by Centers for Medicare & Medicaid Services (CMS) and commercial payers. During 2015, additional "incentives" will emerge with the start of CMS claim payment reductions (Medicare only) for physicians that fail to meet meaningful use (MU). So, we felt that it is worth taking a minute to review early gains and some lessons learned.

Increases in EHR Technology Adoption

Hsioa, et. al. reports that in 2012, 64% of physicians routinely received the results of a patient's consultation with a provider outside of their practice. A higher percentage of physicians using health IT received patient information necessary for care coordination than those who did not use health IT. "The study findings highlight the continuing challenges to using health IT to coordinate care among providers."

In 2013, the third year of the federal electronic health record incentive (EHRI) program, nearly 8 in 10 office-based physicians had adopted some form of an EHR, and nearly half of them had a "basic" system (those that provide only "key" EHR functions). Rates for multi-featured, "fully functional" EHRs, also rose significantly, albeit from even lower levels of adoption (16.8% in 2011; 23.5% in 2012; 31.1% in 2013). They also reported that 69% of physicians surveyed reported that they intended to participate in the Medicare and Medicaid EHRIs.

More recently, we are seeing a slowing of the pace of adoption. The National Ambulatory Medical Care Survey, conducted in June 2013, showed only about 13% of all office-based physicians reported that they both intended to participate in Stage 2 of the federal EHR incentive payment program and "had EHR systems with the capabilities to support 14 of the 17 Stage 2 core set objectives for meaningful use."

Increased Expectations on Care Coordination by PCMH Programs

On a parallel track, CMS and other insurers have been providing incentives and/or new codes to reimburse physicians for some Patient Centered Medical Home (PCMH) services

The Patient Centered Primary Care Collaborative (PCPCC) report showed that nearly 20 million patients were being cared for in a PCMH setting by the end of 2013. The report calls for increased spending on primary care and a restructuring of payments to support enhanced primary care efforts, including coordinated care. Their report specifically cited the following needs:

- Incentives such as shared savings should be paid in the second or third year of the program
- Care teams need training to handle multiple tasks to preserve the physician's time
- All participating institutions need access to patient information at a specified point

At the same time as the EHRI was launched, The CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) got under way. The MAPCP is providing support to help practices transform the way they deliver and coordinate care, including use of nurse care managers or care coordinators, restructuring of staff, improvements in patient flow, adoption of health information technology, and more frequent staff meetings.

The EHRI has always been viewed as an important element in the ultimate success of such care coordination programs as the PCMH. The 1st Stage of the EHRI included an expectation to run a population analysis report provided by an EHR, and a modest optional requirement to electronically exchange patient care summaries. The 2nd Stage of the EHRI is designed to, among other things, ramp up requirements to exchange clinical information amongst care providers.

Shared Risk in ACOs Fundamentally Requires Strengthened Care Coordination

The newest care coordination driver from CMS is the Medicare Shared Savings Program (MSSP) available to Accountable Care Organizations (ACOs). This program focuses on improved patient care planning and coordination to reduce the rates of avoidable hospital readmissions. While the ultimate success of these programs depends upon a number of factors, electronic exchange of clinical information amongst coordinated providers is a pivotal tool.

Conclusion: Lessons Learned

The good news is that we are beginning to see isolated positive results. The disappointing news is that these results are going to take a while for us to see them occur broadly. For those working in the trenches implementing the necessary workflow transformations, these findings are in line with expectations. As an example, Geisinger Health is a very early entrant into this transformation effort. A 2009 Primary-centered

Primary Care Collaborative (PCPCP) report revealed their PCMH program produced a 50% reduction in ED visits and 15% reductions in inpatient admissions.

Even with successful projects, all of these coordination programs are reporting similar experiences:

- Care transformation is required and is not a quick, simple effort
- HIT products, especially the initial EHRs, do not provide robust care coordination features (though this is changing)
- Universally, the infrastructure to exchange information (HIEs) amongst the care team is not coming online as quickly as hoped
- Managing complex chronic cases involves a lot more than coordination
- The kind of data analytics that can allow us to identify levels of patient risk is not a simple matter and will require time to make a reality

Improvements in care coordination are not a new goal in healthcare. But what is new today is that we have the tools to truly enable it:

- Healthcare quality and cost control imperatives
- Public policy and funding to support it
- Sufficient information technology capabilities that must be appropriately harnessed
- Payer willingness to reimburse coordination services via various approaches

Finally, we have the willingness of most practitioners to make it happen. While there are legitimate signals of fatigue, all we need now is to continue to learn from our various efforts, and persist in harnessing HIT capabilities to truly virtually integrate our health team around the needs of the patient.

Editors:

Hank Mayers, FHIMSS, President of ReliaTechConsulting, LLC, & Adjunct Professor of HIT at Western Michigan University. Co-chair for the HIMSS Care Coordination Task Force and Chairperson of HIMSS Transitions of Care Work Group.

Antonio Linares, M.D., Regional VP, and National Medical Director at Anthem Blue Cross-WellPoint, Inc., Co-chair for the HIMSS Care Coordination Task Force and HIMSS Transitions of Care Work Group Member.

HIMSS Staff:

Ian E. Hoffberg, Manager, Healthcare Information Systems (HIS), HIMSS