



*A Federally Qualified Non-Profit Community Health Center on Cape Cod*

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September 23<sup>rd</sup>, 2013

David Seltz, Executive Director  
Health Policy Commission  
Two Boylston Street,  
Sixth Floor,  
Boston, MA 02116

Dear Mr. Seltz,

Outer Cape Health Services, Inc. (OCHS) is pleased to submit the following testimony to the Health Policy Commission. We appreciate the opportunity to provide evidence of our efforts to promote high quality and efficient care. OCHS, a Federally Qualified Health Center (FQHC), is dedicated to providing “a full range of primary health care and supportive social services that promote the health and well-being of all who live in or visit the eight outermost towns on Cape Cod.” OCHS has a long standing non-exclusive affiliation with Beth Israel Deaconess Medical Center (BIDMC). OCHS contracts with most non-public insurers through its Beth Israel Deaconess Care Organization (BIDCO) but refers over 85 percent of patients requiring hospitalization and specialty outpatient consultation to Cape Cod Hospital in Hyannis.

- 1) **Chapter 224 of the Acts of 2012 (c.224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state’s economy. The benchmark for the growth between CY2012-CY2013 and CY2013-CY2014 is 3.6%.**
  - a. **What are the actions your organization has undertaken to reduce the total cost of care for your patients?**
  - b. **What are the biggest opportunities to improve the quality and efficiency of care at your organization? What current factors limit your ability to address these opportunities?**
  - c. **What systematic or policy changes would encourage or help organizations like yours to operate more efficiently without reducing quality?**
  - d. **What steps are you taking to ensure that any reduction in health care costs is passed along to consumers and businesses?**

OCHS has gone through a major turnaround since 2009. I was hired as CEO January 6, 2010, after having served six weeks in an interim role. At the time, OCHS had two medical centers (Provincetown Community Health Center and Wellfleet Community Health Center) and served a patient population of 10,500, and 30,500 patient visits per year. Because OCHS had sustained many years of operating losses, the organization could not sufficiently maintain or update its infrastructure.

In late January, 2010, Mass. Department of Public Health (DPH) Division of Health Care Licensure and Quality conducted a site review and mandated improvements including emergency repairs to both centers' facilities that cost over \$800,000. It was a mandate that forced our Board of Directors and senior management team into action in order to preserve the much needed care in our community. With the combination of debt financing from TD Bank and USDA, and initial federal stimulus funding, we were able to make the necessary short term remediation to the two health centers. With subsequent federal stimulus funding, OCHS was able to make long-term remediation to the Provincetown Health Center in 2013, but has not yet been able to raise or borrow sufficient funds to implement its proposed plans to replace the Wellfleet Health Center (now 47 years old) as DPH has required by October, 2013. In late December, 2009 we also looked critically at the salaries and benefits offered to our physician and mid-level providers. In an attempt to recruit new providers and retain long term ones, effective January 1, 2010, we both equalized salaries by seniority and improved benefits including adding a retirement match and bonus incentive structure with both quality and productivity components.

In August 2011, OCHS opened the Harwich Community Health Center to meet the demand of the Lower Cape area in a leased five exam room facility. OCHS opened Harwich CHC under Emergency Licensure waivers from DPH requiring OCHS to have a viable plan for replacing the facility by January 2014. A loan application to US Department of Agriculture (USDA) was submitted in August, 2013 for \$19,750M to rebuild the Wellfleet and Harwich CHC's as required by DPH as one potential source of the funds to replace the two facilities.

We also realized that access to affordable drugs was a major issue for our patient population, so in July 2011, we leveraged our FQHC status to open a 340B qualified pharmacy in Wellfleet that also serves as the only retail pharmacy in the 30-mile stretch between the towns of Orleans and Provincetown. The OCHS Wellfleet pharmacy has also served as the only Health Safety Net pharmacy provider on Cape Cod and now also serves as the contracted 340 B pharmacy for Duffy Health Center that serves the homeless of Cape Cod. In June 2013, OCHS opened a 340B pharmacy at our Provincetown Health Center (80 percent of Cape Cod's patients with HIV live in OCHS's eight town catchment area) to alleviate the burden of drug cost for patients.

We are proud to announce that, between FY 10 and FY 13, we have grown our patient population by 65 percent (from 10,500 to over 17,000) and annual visits by over 100 percent (from 30,500 to 70,000). We couldn't have done this without a tremendously dedicated team and community and a significant amount of financial investment from funds and programs dedicated to centers like ours. **Therefore, first and foremost, we want to acknowledge the importance of this type of funding; furthermore, we urge Mass Development be directed to float bonds so as to lend funds necessary to sole community or primary care providers to maintain adequate**

**facilities in order to meet the growing demand for care as enabled by both Mass Health Reform and the Affordable Care Act.**

OCHS believes that high quality and efficient care is attainable, and we are working to achieve that through continuous process improvement. To that end, we have identified three key areas to generate immediate and sustaining cost reduction – overhead cost reduction, process improvement and care coordination.

To reduce overhead costs, we purchased in December 2011, with a Mass Development Technology Fund loan of \$250,000, a new server, a telecom systems and a state –of-the-art General Ledger accounting system. These purchases allowed us to replace previously leased systems that were high cost and low performance, upgrade Electronic Medical Record and Practice Management software to meet Meaningful Use, and improve efficiency in accounting and reporting. We also restructured employee insurance coverage by switching to a lower cost carrier and raising deductibles. Other purchasing improvements were made, such as we generated saving by purchasing vaccines directly from the manufacturer.

OCHS has made process improvement a priority; and we have increased productivity by 10 percent over the past year and are on our way to improving it by another 30 percent this fiscal year. Our three clinical sites are participating in the Primary Care Optimal Performance Project where we have identified increasing throughput and maximizing productivity of existing clinical staff as ways to reduce per visit cost. We also switched supply management vendor to one that can accommodate bar coding for inventory management and can integrate 340B drug purchasing program for the pharmacies. This new vendor allows us to better manage supplies at the three sites.

Last but not least, we launched a new care coordination initiative aimed to reduce unnecessary ER visits and inpatient readmissions and otherwise reduce the cost and improve the outcomes of care. In this initiative, we routinely identify high risk patients who have had multiple ER visits, extended observation stays, recent inpatient admissions, or have chronic conditions. Currently we have identified over 100 patients for care coordination. We preemptively provide home visits by NPs or an RN care manager or Licensed Social Worker as an extension of the OCHS primary care provider, prompt follow-up visits after hospitalization, office visit scheduling and individualized patient education. Since the launch of this initiative, we have numerous patients who regularly visited the ER and are now receiving more regular care at our centers instead. It is OCHS's future goal to obtain data to demonstrate the efficacy of this program. We are grateful for the September 2013 EOHHS 'capacity building' grant of \$82k to help expand this program.

OCHS' opportunities to produce ongoing savings are to continuously improve on all three areas mentioned previously, and to further develop our care coordination program aimed to improve patient care and reduce cost.

We believe that our cost reduction efforts mentioned above have had immediate impact to patients and payers, and thereby, businesses and tax payers' health premium cost. Because of these efforts, we have been able to provide the same high quality, low cost care to our patients when Mass Health, our predominant payer for 37 percent of our patients, did not increase

payment rates in the past few years. However, we have been unable to fund amortization and depreciation or provide more than an every other year COLA or merit increase of 2 percent with the freezing of the Mass Health rates. It is imperative that Mass Health both approves the Mass. League of Community Health Center's proposed rate increase of 7.5 percent as of October 1, 2013 and builds in annual inflationary increases into future CHC provider rates, so that we can continue to retain staff and reinvest in infrastructure that will ultimately achieve our goal of providing high quality and efficient care.

- 2) The 2013 Examination of Health Care Cost Trends and Cost Drivers by the Attorney General's Office found that growth in prices for medical care continues to drive overall increases in medical spending. What are the actions your organization has undertaken to address the impact of the growth in prices on medical trend and what have been the results of these actions?**

OCHS believes that to reduce future medical cost trend, we must build a foundation today to improve productivity and quality of care. As described in question one, we launched the Primary Care Optimal Performance Project, a process improvement initiative, at our three sites, and we are on target to see improvements in productivity and reduction in unit cost. Additionally, we have aligned our clinician bonus program with productivity and care quality and outcome measures to further emphasize its importance. Also described in question one, we will continue to develop our care coordination program, and we believe it will demonstrate savings from reduction in ER visit, observation days and hospital readmissions. Collecting and analyzing this data is crucial; however, it is time consuming and costly. We welcome coordinated efforts, such as the Mass League DRVS system that can help us to collect and understand quality metrics and patient outcomes. A coordinated program of care management throughout Health Centers would greatly enhance care for every patient.

- 3) C.224 seeks to promote the integration of behavioral and physical health. What are the actions your organization has undertaken to promote this integration?**
- a. What potential opportunities have you identified for such integration?**
  - b. What challenges have you identified in implementing such integration?**
  - c. What systematic or policy changes would further promote such integration?**

OCHS eight town service area has a combined population of 47,000, in the rural outermost parts of Cape Cod. As expected, our patient population is much more seasonal than most CHC's – out of the 17,000+ patients OCHS served in FY 13, or 70,000+ patient visits provided, 20 percent of are seasonal. The year round population has a high percentage of aging and seasonally unemployed patients. The most prevalent mental and behavioral conditions we treat are depression, bipolar disorder, substance abuse and cognitive disorders related to aging. Of the 20 primary care 'pods' within the BIDCO affiliated primary care practice groups, OCHS has the highest overall acuity score as a high portion of our year round patients have chronic, complex medical, mental and substance abuse conditions.

Being a rural provider and virtually the sole primary care provider in the outer cape towns and the fastest growing primary care provider in the lower cape communities, we understand that access to care is a major issue – both in terms of availability of providers and transportation. Our Board eligible psychiatrist is currently the only adult psychiatrist accepting new patients on Cape Cod. Therefore, it is important that our centers are integrated with physical and mental care. Furthermore, as we further develop accountable care, it is imperative that we address and care for patients' whole health.

As a step towards integration, OCHS is currently undergoing an expansion to our medical clinic licensure to include state licensure for mental health services. Our biggest challenge to date is recruiting a Board certified psychiatrist to join our centers, which the state's shortage of psychiatrists, our rural location and payer mix are the main obstacles. While we have added a dually board eligible psychiatrist in 2013, he is not Board certified, so we are, as of yet, unable to file for an expansion of our licensure to serve as a licensed mental health clinic. We appreciate DPH's recent decision to review a waiver to the requirement. Without such waiver, we are unable to bill insurers for the mental services provided and sustain this important care. Another key integration with physical and mental care is the OCHS Office Based Opioid Treatment (OBOT) Program, which is currently the largest program of its type on Cape Cod for patients in recovery from narcotic (heroin or other narcotics, such as the illicit use of prescription opiates) substance abuse. Currently 140 patients meet weekly with an addiction-trained RN who coordinates formal psychiatric care, OBOT licensed OCHS physician care and primary care as well as weekly counseling and monitoring using formal protocols. Patients are mandated to have regular primary care at our health centers not just treatment of substance abuse. We will expand our program to 160 patients in care this autumn. Partnership in caring for our patients is crucial. Gosnold of Cape Cod, the Cape's largest counseling agency for people seeking help for substance abuse issues, has partnered with OCHS to co-lead our OBOT support groups, currently held at the Wellfleet Council of Aging.

As mentioned previously, our two OCHS Licensed Social Workers also provide home visits as part of the primary care team for vulnerable patients in our care coordination program as of 2013. In this way, we are trying to reach patients with psychosocial as well as physical challenges to help them safely 'age in place' in their homes.

We believe a key factor that mental health integration lags behind is current regulations and payment policy around mental health services. Compared to physical health services, many more mental health services are not reimbursable, or not reimbursable when provided on the same day of a medical visit. In order for providers to fully integrate mental and physical health services, regulations must complement the integration. We respectfully ask the Commission to review current mental health regulations and payment policy to make necessary changes to encourage integration.

Also, we join all CHC's and Cape Cod Hospital in expressing a need to change the contracting practices of both Mass Department of Mental Health (DMH)'s (for children and adults' who are seriously mentally ill) and DPH's (for care for those with alcohol and substance abuse disorders)

for various components of the necessary continuums of care. On October 4<sup>th</sup>, 2013, there will be a Mental Health and Substance Abuse Summit for Cape Cod providers to coordinate our vision for an improved system of care so as to propose a new system for DMH and DPH resources provided to the residents of Cape Cod. Presently, DMH provides an off Cape in patient unit and contracts with over a dozen off-Cape agencies for various components of mental health care and DPH provides a similar uncoordinated set of contracts for various components of alcohol and substance abuse care. A wholly re-organized, re-developed and re-contracted system that is locally integrated into Cape Cod CHC's, Cape Cod Healthcare and other Cape practices is needed. Such a locally integrated and accountable system is necessary to provide the continuum of care necessary to reduce, intervene early, and be effective in providing the mental health and substance abuse care necessary to lower the cost and improve the outcomes of patient care on Cape Cod.

- 4) C. 224 seeks to promote more efficient and accountable care through innovative care delivery models and/or alternative payment methods.**
- a. Describe your organization's efforts to promote these goals.**
  - b. What current factors limit your ability to promote these goals?**
  - c. What systematic or policy changes would support your ability to promote more efficient and accountable care?**

OCHS is the main primary care health provider in the Outer Cape where our Provincetown and Wellfleet Health Centers have operated for 41 and 47 years respectively, and a growing presence in the Lower Cape service area where our Harwich Community Health Center has operated for the past two years. The closest hospital is Cape Cod Hospital, which is over 50 miles away from Provincetown, and 30 miles from Wellfleet, where most of our patients are admitted and cared for most acute conditions. We are committed to serving our patients and community by improving care and reducing cost. That is the driving force behind our decision to participate in the BIDCO Medicare Pioneer ACO contract starting January, 2014, where we can build on our prior experience since 2010 within BIDCO's Alternative Quality Contracts with commercial insurers managing cost and quality. However, while BIDMC is a Tier Two (lower) cost hospital, Cape Cod Hospital is a Tier One (higher cost, like Mass General Hospital) cost hospital putting OCHS at a disadvantage in shared financial risk contracts.

As described in question one, we launched a care coordination program that has achieved improvement in reducing unnecessary ER visits and hospital re admissions. Our home visit program was started in 2012. It is now staffed by two senior nurse practitioners skilled in geriatric medicine and a senior registered nurse with long experience providing case management and home care. The care coordination team now umbrellas the home visit program as only one of the care coordination services and is under the direction of our Medical Director. This program is the launching off point for our future ACO participation.

As we drive for more accountable care, we are faced with a few challenges:

1. The rural nature of our community presents transportation and technology challenges. This could increase our cost of providing care; for example, if our team serving a

catchment area of the eight towns from Provincetown to Chatham can only make three home visits per day, whereas our urban counterparts can make six visits, our unit cost will be higher. Also, mobile technology, a key tool in care coordination, often times does not work in many remote areas we serve. Cell phone and Internet reception in many areas of the Outer Cape like Truro or Provincetown can be spotty at best, making it challenging to place calls to other agencies (for lab services, or to contact the Visiting nurses, for example) and to use our Electronic Health Record efficiently in the home.

2. We believe that we can better leverage the EMR technology to provide more care coordination functions; however, we need to become more proficient users of the technology and have stepped up our investment in staff training to do so.
3. In care coordination and population management, patient data is important. Like most providers, we do not have access to timely and sufficient patient utilization data across continuum of care. This level of data, measured continuously and made available in a timely fashion, can help providers track care coordination process and identify areas for improvement, thus is an immensely helpful tool.

In light of the challenges mentioned above, we ask the Commission and policymakers to provide infrastructure funding, either in grants or management fees, to rural providers that may require assistance in getting care coordination system up and running. Furthermore, we ask the payers of accountable care contracts to provide patient utilization data in a timely fashion to assist in our care coordination process.

Separately, OCHS requests a cost and quality improvement from an appeal we have made to DPH. In 2005, OCHS was given a 'waiver' from Emergency Medical Services regulations at DPH to enable Provincetown and Wellfleet Health Centers to 'accept' low risk (priority level 3) transfers from EMS personnel who has a patient with a low risk condition (e.g., ankle sprain). Because Provincetown, Truro and Wellfleet are located so far from Hyannis, tying up one of four EMS vehicles that serve this three-town area (8,500 people even in the dead of winter; 50,000 people in the summer) presents a risk to those who really need to be stabilized and transferred to Cape Cod Hospital (e.g., heart attack or trauma). OCHS triages and transfers hundreds of patients each year (900 annually from Provincetown alone). Add bad weather such as a hurricane or Nor'Easter or summer grid lock traffic and you have a recipe for someone dying without transport. While OCHS can stabilize someone for hours if necessary at one of our health centers, this is challenging with very limited exam rooms and staff. However, our ability to triage and treat low risk conditions helps the whole system both improve outcomes (early treatment) and reduce costs (OCHS average visit receipt is \$125 vs. the ER visit starts at \$900). When OCHS almost lost licensure at both of our facilities in January, 2010, Dr. Madeline Bondillilo, even upon appeal, in October, 2011, would not reinstate the waiver to accept low risk EMS transfers to Provincetown and Wellfleet Health Centers. There has been and continues to be solid support from everyone including the Medical Director of the ER at Cape Cod Hospital to SE Mass Regional EMS Transport system for reinstating the waiver to OCHS to accept low risk EMS transfers when appropriate. We believe the Commission's support for reinstatement of this waiver for OCHS's Provincetown and Wellfleet Health Centers will not only save the system and

insurers cost but will also save lives by keeping limited EMS vehicles and staff for this region available for true medical emergency and transport care.

- 5) What metrics does your organization use to track trends in your organization's operational costs?**
- a. What unit(s) of analysis do you use to track cost structure (e.g. at organization, practice, and/or provider level)?**
  - b. How does your organization benchmark its performance on operational cost structure against peer organizations?**
  - c. How does your organization manage performance on these metrics?**

In the Primary Care Optimal Performance Project, we measure the three sites using five metrics: 1) patient satisfaction, 2) staff satisfaction, 3) cost per visit, 4) visits per hour, and 5) a panel of Type II diabetes outcome metrics. We benchmark our performance in these five areas against the averages of national cohort. Our organization tracks each site's progress continuously – we compare the outcomes to our historic benchmarks, as well as national cohort benchmarks. Furthermore, the improved cost metrics are built into OCHS' FY14 budget to ensure that management and staff are committed to the higher efficiency standards. Lastly, as mentioned in question one, OCHS' clinician incentive bonus program is based on each clinician's attainment and improvement in quality and productivity standards.

- 6) Please describe the actions that your organization has undertaken or plans to undertake to provide patients with cost information for health care services and procedures, including the allowed amount or charge and any facility fee, as require by c.224.**

While we support price transparency in principle, we respectfully ask the Commission and policymakers to set a standard methodology under which providers should share pricing and cost information. We are concerned that because there is currently no pricing standard, we may not be able to compare prices across all providers equally. With regards to sharing provider cost information, all providers are required to submit annual cost reports. They are the best and the most standardized cost information available; therefore, they are the best starting point for sharing cost information with the general public.

- 7) After reviewing the reports issued by the Attorney General (April 2013) and the Center for the Health Information and Analysis (August 2013), please provide any commentary on the findings presented in light of your organization's experiences.**

The Attorney General April 2013 Report found that more providers are participating in risk contracts in 2012 than in the previous years. This finding resonates with us; as noted earlier, we are preparing to participate in the Medicare Pioneer ACO in January 2014, and we believe that this is a positive step toward better integrated care for our patient population.

The Center for the Health Information and Analysis 2013 Report found more employers are choosing high deductible health insurance plans as a way to contain cost in a slow economy. As mentioned in question one, we have employed the same cost containment measure in the past



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years. We believe the Report accurately captured the employee sponsored insurance landscape in the past year.

We appreciate the opportunity to provide this testimony. Please feel free to reach out to me with additional questions.

I, Sally Deane, certify that I am legally authorized and empowered to represent and sign on behalf of Outer Cape Health Services, for the purposes of this testimony, and that the testimony is signed under the pains and penalty of perjury.

Sincerely,

A handwritten signature in cursive script that reads "Sally Deane".

Sally Deane, MPH  
Chief Executive Officer