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# A Strategic Roadmap for Meaningful Use, Quality Reporting and Improved Productivity

*presented by*

www.ruralhealthsuccess.com

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# Introductions

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# Framing the Challenge

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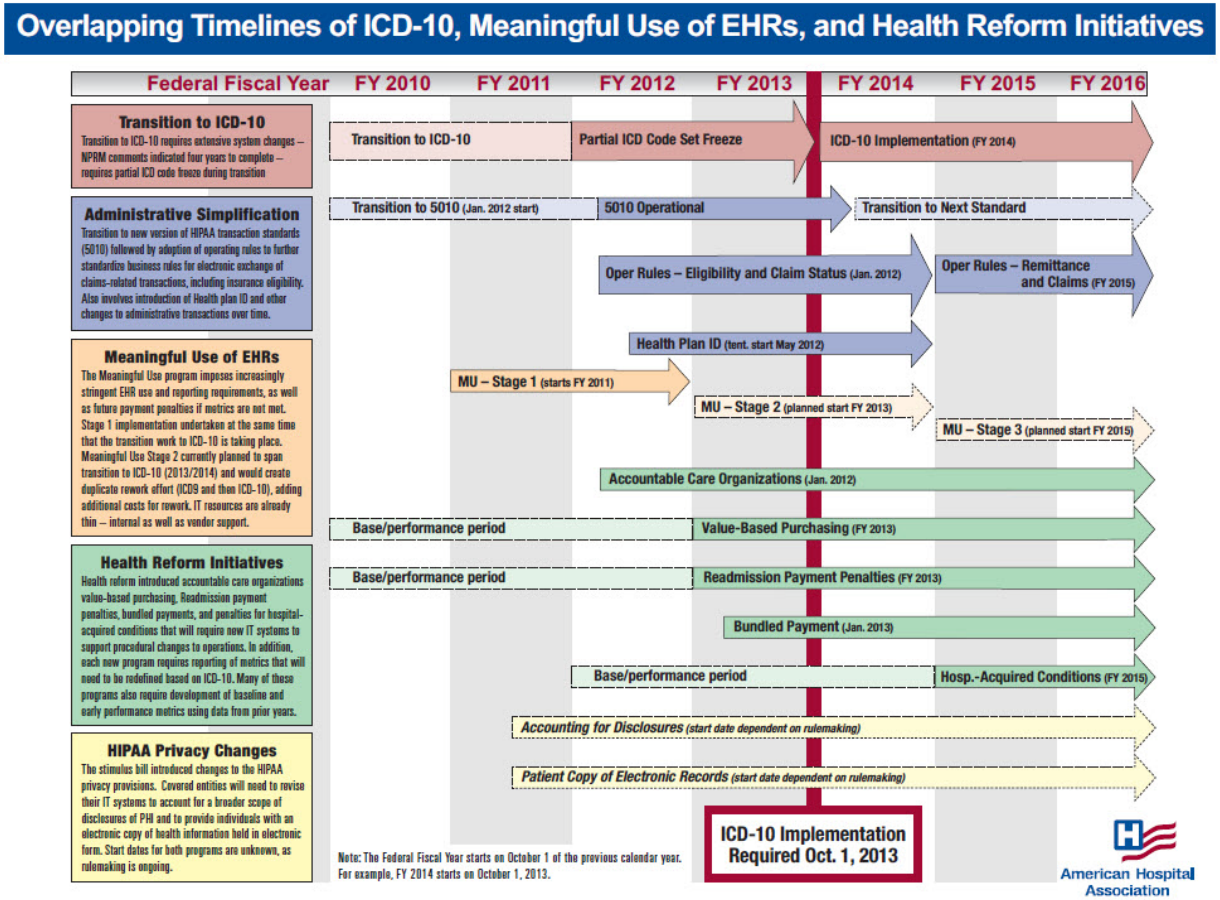
# Competing Priorities

- The Challenge
- Meaningful Use
- Quality Reporting
- Productivity
- Implications
- Transformation
- Implementation
- Roadmap
- Questions




Source: American Hospital Association, April 2011

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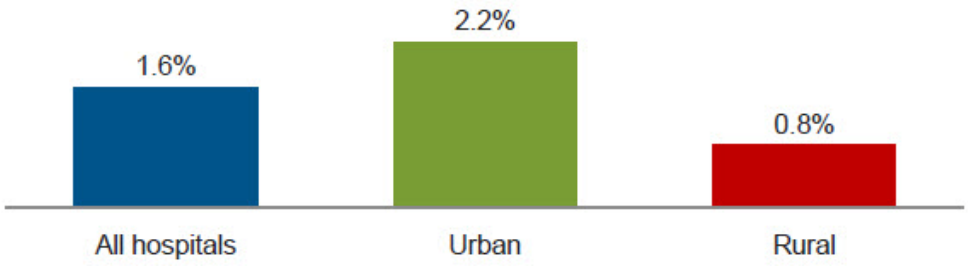
# Readiness Today



Only 1.6% of all hospitals currently report that they meet requirements for meaningful use and have a certified EHR today, while rural hospitals report just 0.8%

*Implications?*




Source: AHA analysis of survey data from 1,297 non-federal, short-term acute care hospitals collected in January 2011. Hospitals were asked to separately identify whether their EHRs were certified for each objective and whether the hospital could meet the objective, regardless of certification. To meet meaningful use, a hospital must (1) possess an EHR certified against all 24 objectives of meaningful use, (2) meet at least 19 of the objectives, and (3) successfully report quality measures generated directly from the EHR. Nationally, there are approximately 2,800 urban hospitals and 2,300 rural hospitals.

Source: American Hospital Association, April 2011

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# Overview



Authorized by The American Recovery and Reinvestment Act (ARRA) of 2009, CMS defines "meaningful use" as providers needing to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity. Its' three main components are the use of certified:

- EHR in a meaningful manner (e.g., e-prescribing)
- EHR technology for electronic health information exchange (HIE) to improve quality of healthcare
- EHR technology to submit clinical quality and other measures

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# Overview



Staged in three steps over a five year span, CMS' criteria is as follows:

- Stage 1 (2011/2012) – Adoption of EHR moving from paper to digital platform
- Stage 2 (expected by 2013) – Connectivity via HIE
- Stage 3 (expected by 2015) – Decision support to improve care
- *Challenge for providers?*
  - Further expansion on this baseline is to be developed through future rule making, so the challenge becomes how best to strategically predict the future?

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# Incentives



To qualify for incentives, meaningful use requirements must be met in the following ways:

- Medicare/Medicaid EHR Incentive Programs – Eligible providers (EPs) must demonstrate meaningful use, first through attestation, then through HIE transaction by way of certified EHR technology every year they participate in the programs in the following ways:
  - Adopted: Acquired and installed certified EHR technology
  - Implemented: Began using certified EHR technology
  - Upgraded: Expanded existing technology to meet certification requirements. (e.g., add new functionality)

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# Medicare and Medicaid



## Side-by-Side Comparison Reveals Notable Differences

| Medicare | Medicaid |
|---|---|
| Federal Government will implement (will be an option nationally) | Voluntary for States to implement (may not be an option in every State) |
| Payment reductions begin in 2015 for providers that do not demonstrate Meaningful Use | No Medicaid payment reductions |
| Must demonstrate MU in Year 1 | A/I/U option for 1st participation year |
| Maximum incentive is $44,000 for EPs (bonus for EPs in HPSAs) | Maximum incentive is $63,750 for EPs |
| MU definition is common for Medicare | States can adopt certain additional requirements for MU |
| Last year a provider may initiate program is 2014; Last year to register is 2016; Payment adjustments begin in 2015 | Last year a provider may initiate program is 2016; Last year to register is 2016 |
| Only physicians, subsection (d) hospitals and CAHs | 5 types of EPs, acute care hospitals (including CAHs) and children's hospitals |

Source: HHS Office of the National Coordinator for HIT ,January 2011

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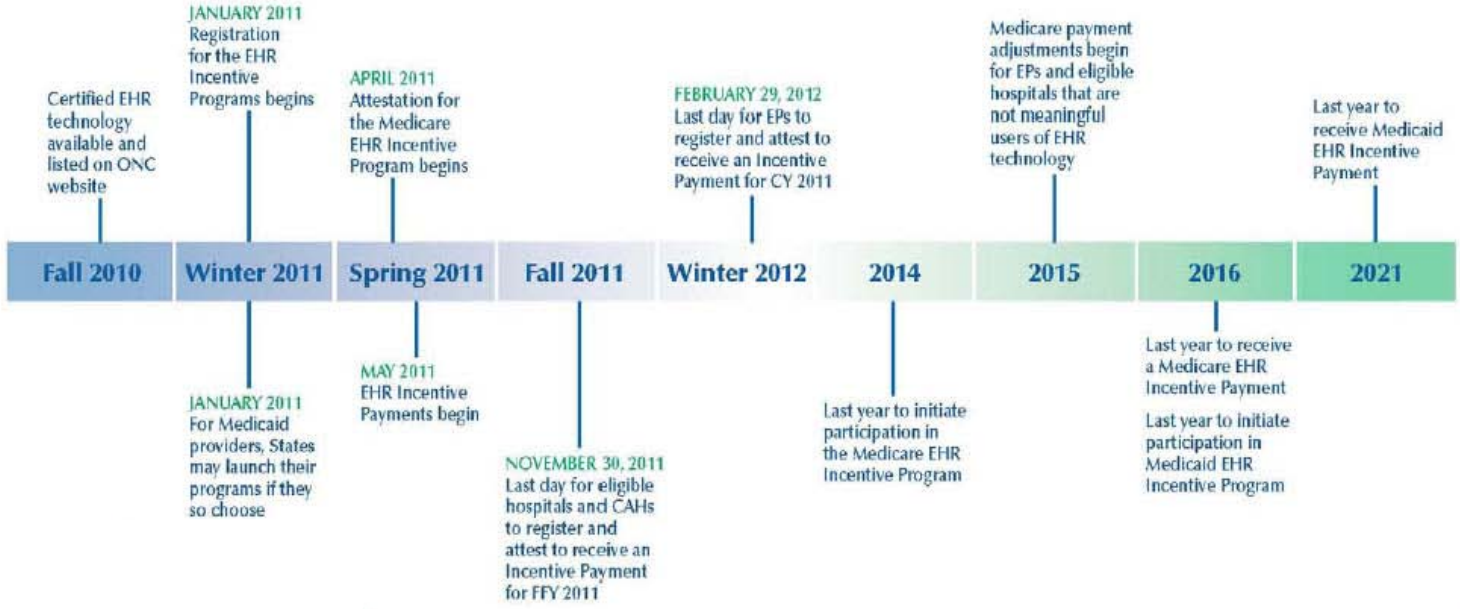
# CMS Timeline



## EHR Incentive Program Milestones for Medicare and Medicaid




Source: Meaningful Use Timeline, Centers for Medicare and Medicaid Services, April 2011

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# Incentives Timeline

- The Challenge
- Meaningful Use
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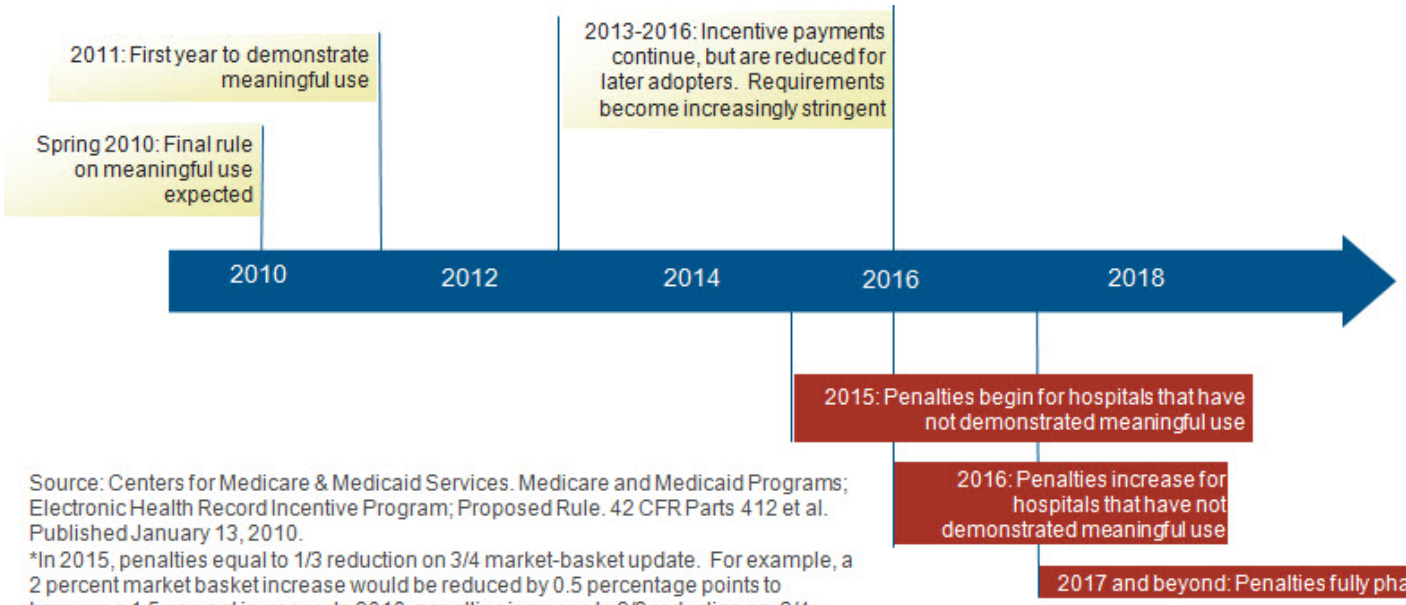
Hospitals are eligible for incentives in 2011 and subject to penalties in 2015




Source: Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule. 42 CFR Parts 412 et al. Published January 13, 2010.
*In 2015, penalties equal to 1/3 reduction on 3/4 market-basket update. For example, a 2 percent market basket increase would be reduced by 0.5 percentage points to become a 1.5 percent increase. In 2016, penalties increase to 2/3 reduction on 3/4 market-basket update. In 2017, penalties increase to full market-basket reduction.

Source: The Road to Meaningful Use, American Hospital Association's TRENDWATCH , April 2010

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# Industry Expectations

- The Challenge
- Meaningful Use
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Many hospitals expect to incur a financial penalty for failing to achieve meaningful use by 2015


Source: American Hospital Association analysis of survey data from 795 non-federal, short-term acute care hospitals collected in January and February 2010. *Excluding critical access hospitals.
Note: Hospital responses based on meaningful use as defined in the proposed rule released by the Centers for Medicare & Medicaid Services in January 2010. Responses may change based on final meaningful use specifications.

Source: The Road to Meaningful Use, American Hospital Association's TRENDWATCH , April 2010

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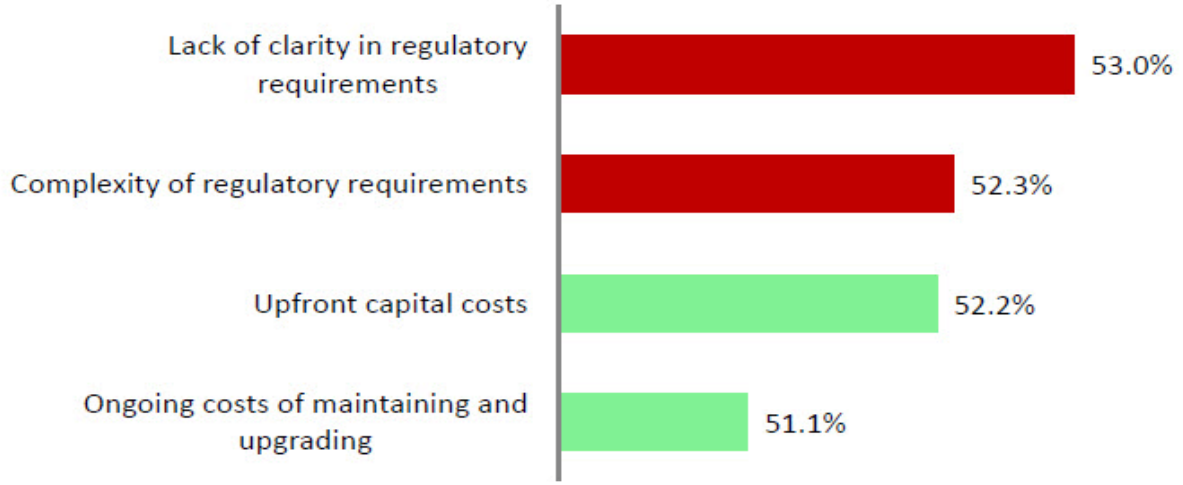
# Industry Barriers



Hospitals largely identify confusion, complexity and costs as barriers to achieving meaningful use in a timely manner




Source: AHA analysis of survey data from 1,297 non-federal, short-term acute care hospitals collected in January 2011.

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# Upfront Costs

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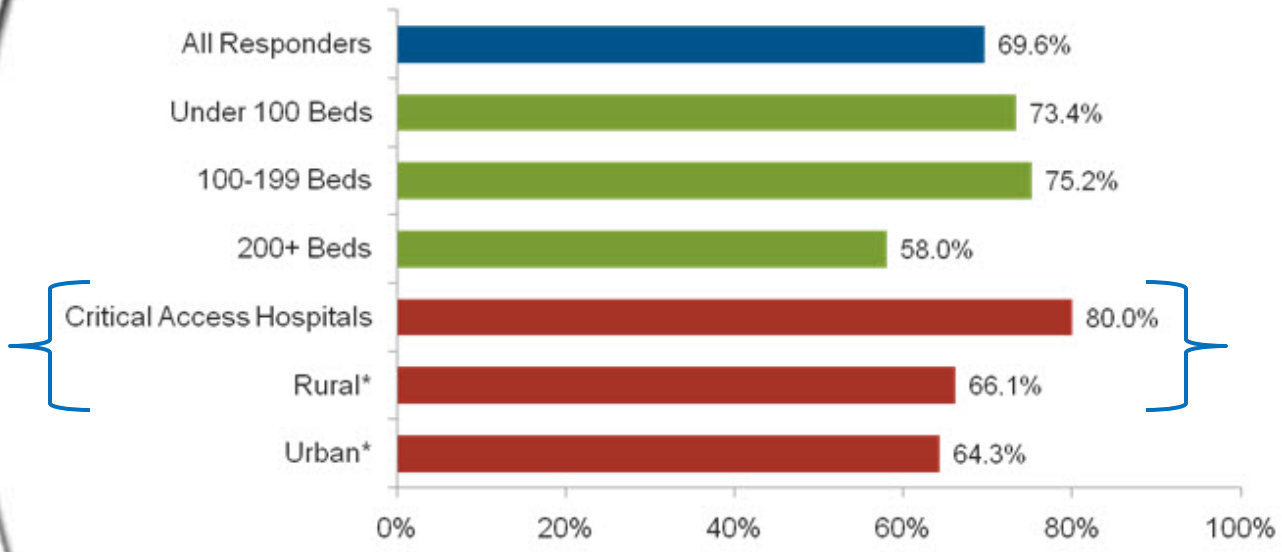
Nearly 70% of hospitals cited upfront costs as barrier to achieving meaningful use and percentages are even higher for CAHs

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# Overview



- Physicians and hospitals required to provide quality measures as a condition of MU
- Quality reporting is a complex and challenging under MU
- Most HIT data captured so far is claims and administrative data versus clinical data
- Quality reporting under MU is a paradigm shift in how HIT data is collected and reported
- Requires turnkey development of *clinical business intelligence systems* to capture data in MU-compatible formats

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# Eligible Professionals



- EPs' quality reporting is equally or more complex than hospital requirements
- EPs are required to report on clinical quality measures (CQM) from a table of 44 CQMs that include 3 "core", "3 "alternative" and 38 "additional" measures
- EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures
- Physician Quality Reporting System (PQRS) – formerly the Physician Quality Reporting Initiative (PQRI) – provides MU incentives to physicians reporting quality data to Medicare

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# Hospitals



- According to rule, hospitals must report 35 quality measures to meet MU requirements
- In MU final rule, hospital quality measures:

  *"…consist of measures of processes, experience and/or outcomes of patient care, observations, or treatment that relate to one or more quality aims for health care, such as effective, safe, efficient, patient-centered, equitable and timely care."*
- In ARRA, the HITECH Act establishes incentives for hospitals and providers to adopt EHRs

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# Hospitals



For HITECH Stage 1, there are 15 measures specified for Medicare/Medicaid incentive plans (more in Stages 2 and 3):

1. Emergency Department Throughput – admitted patients – Median time from ED arrival to ED departure for admitted patients
2. Emergency Department Throughput – admitted patients – Admission decision time to ED departure time for admitted patients
3. Ischemic stroke – Discharge on antithrombotics
4. Ischemic stroke – Anticoagulation for A-fib/flutte
5. Ischemic stroke – Thrombolytic therapy for patients arriving w/i 2 hrs of symptom onset
6. Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
7. Ischemic stroke – Discharged on statins
8. Ischemic or hemorrhagic stroke – Stroke education
9. Ischemic or hemorrhagic stroke – Rehabilitation assessment
10. VTE prophylaxis within 24 hours of arrival
11. Intensive Care Unit VTE prophylaxis
12. VTE – Anticoagulation overlap therapy
13. VTE – Platelet monitoring on unfractionated heparin
14. VTE discharge instructions
15. Incidence of potentially preventable VTE

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# Additional Factors



Attestation: Initial quality reporting for hospitals and EPs will be done through attestation to CMS until HHS can electronically accept data on clinical quality measures from EHRs – targeted for 2012

- Quality measures are often simple percentage calculations with a numerator and dominator
- Elements of complexity and nuance in developing and reporting quality measures:
  - IT “bandwidth” needed to capture data
  - Assumptions included in calculating measures

***“Devils-in-the-Details”***

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# Rural Health Implications



- MU quality reporting requirements for hospitals and EPs are complex and cumbersome
- Rural providers are challenged compared to urban counterparts because of less access to expertise and capital
- Practical strategies/tactics for rural providers:
  - Be proactive
  - Educate and update Board, staff and physicians
  - Partner with other providers for scale and shared expertise
  - Dedicate resources (dollars and people) to the effort
  - Develop partnership with reliable EHR certified vendor

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# Physicians



- Rural physicians are productive and savvy and are often “early adopters” of new technology
- Examples include:
  - PDAs
  - Smart phones
  - Endoscopy
  - Laparoscopes
  - Telemedicine

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# Hospitals and Clinics



- Similarly rural hospitals and clinics are productive and savvy and are often “early adopters” of new technology (depending on funding – like MU incentives)
  - HIPAA Privacy / AS, Health reform (e.g., ACOs), ICD-10
- Expect **initial reduction** in productivity, due to staff’s “learning-curve” for implementing HIT
- After learning curve conquered – a marked increase in productivity will occur
- Implementing HIT in rural settings should improve:
  - Patient outcomes and quality
  - Productivity and efficiency
  - Business processes

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# The Big Picture

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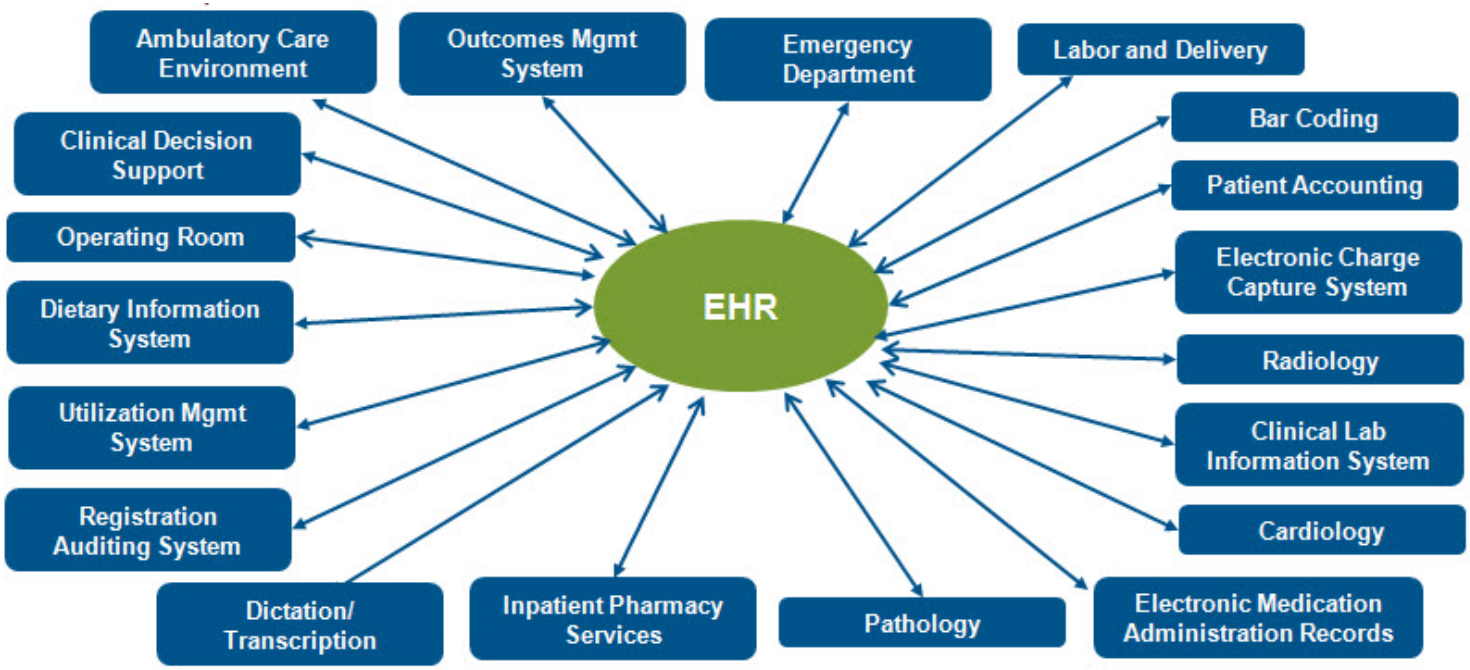
Hospital EHRs integrate many diverse information components




Source: The Road to Meaningful Use, American Hospital Association's TRENDWATCH , April 2010

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# Barriers and Accelerators



- Several barriers face rural health providers
  - Lack of diverse payer mix makes financing more difficult
  - Limited availability of staff with requisite IT expertise
  - Low margins challenge ROI from sizable IT investments
  - Larger dependency on outside technical support, adding costs
  - Lack of interoperability with legacy systems already in place
  - Greater risk of unique connectivity issues
  - Limited alliance potential
- As a result, rural health providers have experienced slower pace of adoption on the technology curve
  - Strategies leading to right solutions to address barriers critical to survival
  - The foundational accelerator in adoption is transformational change management

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# Transformational Change

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Source: Adapted from Harvard Business Review, "Leading Change, " John P. Kotter

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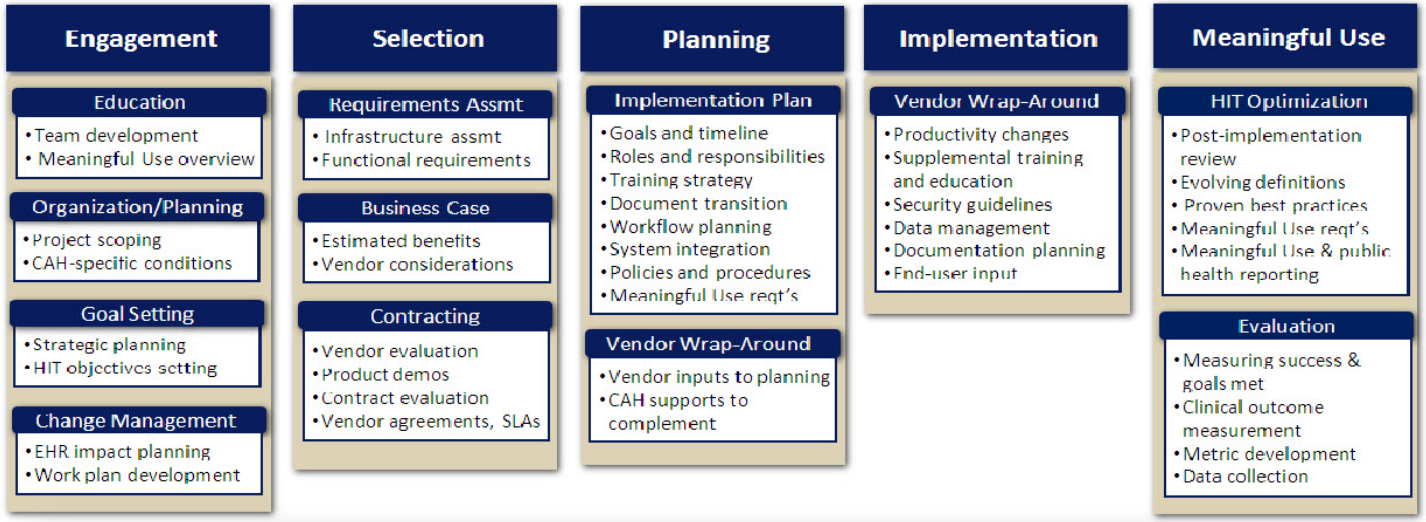
# Process






Source: Adapted from Meaningful Use and CAHs: A Primer on HIT Adoption in the Rural Health Care Setting, HHS and HRSA, December 2010

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# Engagement



- Engagement is essential 1st step to educate staff on HIT adoption – *"priming-the-pump"*
- Identification of roles/responsibilities, current processes, goals and objectives to prepare for HIT change process
  - Examples of roles to be assigned:
    - Project Leader / Adoption Manager
    - Clinical Champion
    - Systems Administrator / IT Director
  - Additional considerations:
    - Education
    - Organization and initial planning
    - Goal setting and change management

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# Selection



- Comprehensive review of the rural provider's technology infrastructure to:
  - Identify HIT vendor products (e.g., certified EHR) that support goals and facilitates implementation of MU functionalities
  - Implement tools supporting negotiation of appropriate contract terms for an effective rural provider/vendor relationships
- Additional considerations:
  - Requirements assessment and building a business case
  - Due diligence and vendor contracting

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# Planning



- Preparing for HIT implementation to “go-live”
- Building change management strategies to develop transition plans for efficient technical and operational integration of the selected HIT
- HIT vendor “wrap-around” is key at this stage– the rural provider/ vendor contract should specify implementation steps
- Additional considerations:
  - Review existing best practices to implementing an EHR and adapt for your purposes
  - Use training materials and best practices from the vendor, government sources, etc.
  - Map out transition and workflow planning processes
  - Revise or develop policies/procedures needed for HIT implementation
  - Work with vendor to assign responsibilities and establish work break down (WBS) and timelines
  - Focus on MU requirements during planning

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# Implementation



- Implementation efforts should “wrap-around” those provided directly by vendors – Helps ensure HIT product architecture aligns with workflows, supports goals and objectives adequate to support HIT use

- Additional considerations:
  - Consider training and educational needs of staff
  - Prepare for reduced productivity, due to staff “learning-curve”
  - Develop a system for end-user support, possibly separately from vendor’s help desk
  - Explore supplemental training modules for refresher courses, training modules to implement new MU requirements
  - Designate one person to stay current on changing MU objectives, related ONC / HHS / CMS rules, reporting, certification and standards requirements

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# Meaningful Use



- Implement MU activities that leverage HIT tools to improve:
  - Patient care
  - Business operations
  - Health outcomes
- During HIT planning and at this point, providers may need assistance to receive available Medicare and/or Medicaid incentive payments
  - Conduct a post-implementation review
  - Consider if/how HIT implementation achieved defined goals
  - Evaluate appropriateness/suitability of HIT for rural inpatient, outpatient and clinic settings

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# Best Practice Model

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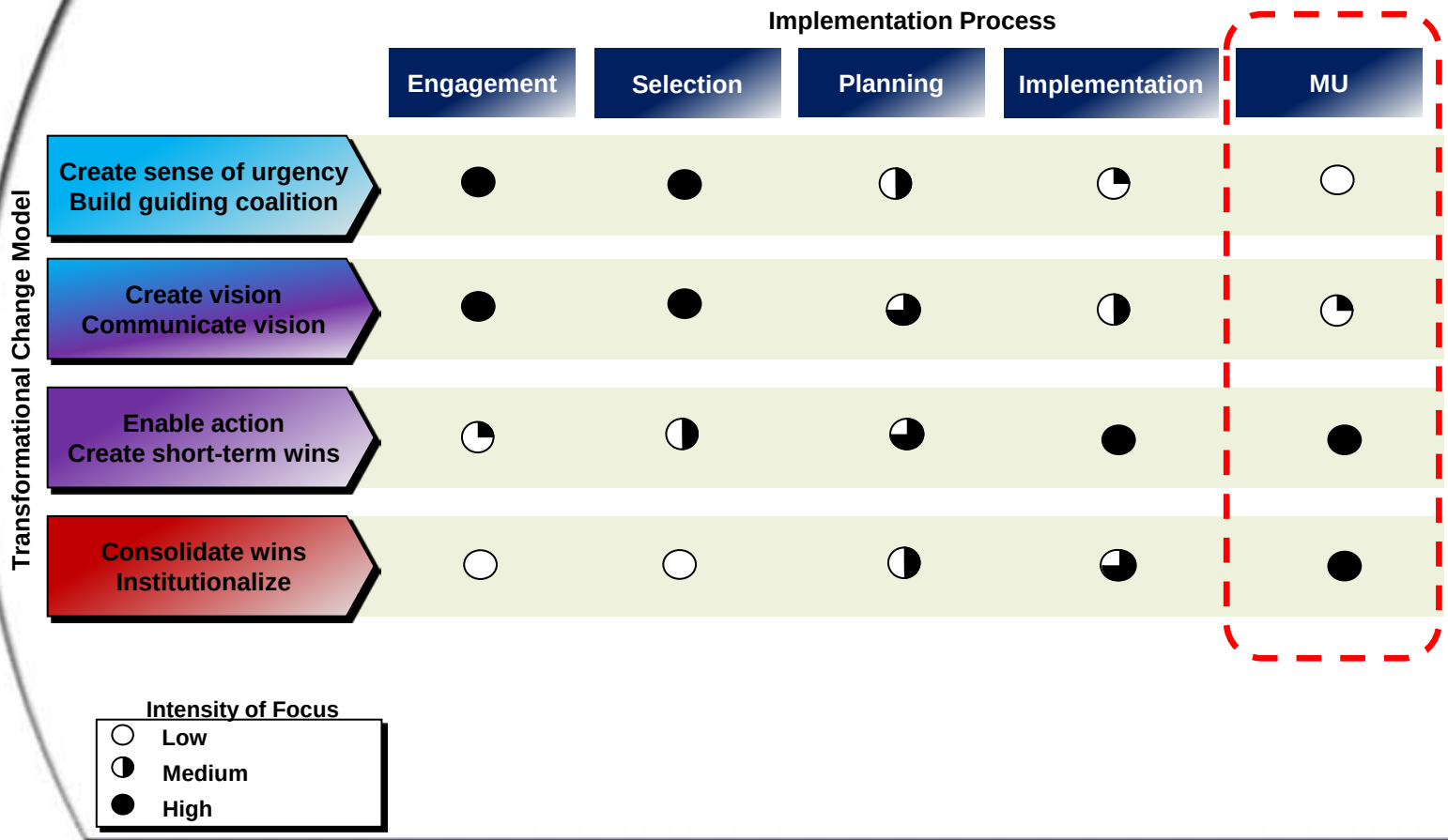

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# Strategic Implications

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# Questions